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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

RACHEL MEHR; BEATA IVANAUSKIENE,
as parent of minor R.K.I. JR.; SARAH
ARANDA, as parent of minors B.A., D.A.,
AND I.A.; KIRA AKKA-SEIDEL; KAREN
CHRISTINE O'DONOGHUE, as parent of
minor L.L.M., on behalf of themselves and all
others similarly situated,

Plaintiffs,

v.

FÉDÉRATION INTERNATIONALE DE
FOOTBALL ASSOCIATION a/k/a "FIFA;"
THE UNITED STATES SOCCER
FEDERATION, INC.; US YOUTH SOCCER
ASSOCIATION, INC.; AMERICAN YOUTH
SOCCER ORGANIZATION; NATIONAL
ASSOCIATION OF COMPETITIVE SOCCER
CLUBS, INC. d/b/a/ US CLUB SOCCER, and
CALIFORNIA YOUTH SOCCER
ASSOCIATION,

Defendants.

No. 14-cv-3879

CLASS ACTION COMPLAINT

DEMAND FOR JURY TRIAL

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1 Plaintiffs Rachel Mehr; Beata Ivanauskiene (“Mrs. Ivanauskiene”), as parent of minor R.K.I.
 2 Jr. (“R.K.I.”);¹ Sarah Aranda (“Mrs. Aranda”), as parent of minors B.A., D.A., and I.A.; Kira Akka-
 3 Seidel; Karen Christine O’Donoghue (“Ms. O’Donoghue”), as parent of minor L.L.M. (collectively,
 4 the “Plaintiffs”), on behalf of themselves and all others similarly situated, bring this class action
 5 complaint against Defendants Fédération Internationale de Football Association (“FIFA”), The
 6 United States Soccer Federation, Inc., US Youth Soccer Association, Inc., American Youth Soccer
 7 Organization, US Club Soccer, and California Youth Soccer Association, and complain and allege
 8 upon personal knowledge as to themselves and their own acts and experiences, and, as to all other
 9 matters, upon information and belief, including investigation conducted by their attorneys.

10 I. INTRODUCTION

11 1. Soccer is the world’s most popular sport with over 240 million participants playing at
 12 present. In the United States, there are approximately 8 million youth players in the United States.

13 2. Injuries are an unfortunate part of soccer. Certain injuries, or the impacts from them,
 14 are preventable and the governing soccer authorities have the power to enact and enforce rules that
 15 would prevent or minimize injuries. This case arises from the failure of soccer’s governing
 16 authorities to take steps to reduce injuries.

17 3. For many families soccer is seen as a terrific alternative to football. Parents are often
 18 relieved when their children choose soccer. However, soccer ranks among the top sports in the
 19 number of concussions per game. Female soccer players have a higher per-game concussion rate
 20 than male players. In 2010, more high school soccer players suffered concussions than basketball,
 21 baseball, wrestling, and softball players combined, according to the Center for Injury Research and
 22 Policy in Columbus, Ohio. In that year, female soccer players suffered 25,953 concussions, and male
 23 players, 20,247 concussions.²

24 4. Since at least 2004, if not sooner, there has been an international consensus on how to
 25 diagnose and treat concussed players. Best practices for concussion management include baseline
 26

27 ¹ As required by Federal Rule of Civil Procedure 5.2, minors are referred to herein only by their initials.

28 ² Robert Cantu, Concussion and Our Kids, 2012.

1 testing, strictly enforced return to play rules, and proper medical evaluation. As explained herein, the
 2 defendants have failed to protect soccer players by their failure to enact and enforce best practices for
 3 concussion management.

4 5. Soccer, as differentiated from other sports, is unique in its relationship to concussions
 5 because part of the game involves heading the ball. “Headers” can be a violent striking of the ball,
 6 sometimes with such violent impact that spectators wince and the sound of the impact carries
 7 through the stands.

8 6. At least 30% of concussions in soccer are caused by heading the ball or by attempting
 9 to head the ball and colliding with a player, object, or the ground.³ 11% of children who suffer a
 10 concussion still have symptoms three months later.⁴ Persistent post-concussion symptoms can be
 11 devastating. According to the Ontario Neurotrauma Foundation, persistent symptoms disrupt daily
 12 living and participation in school and activities.⁵ Children/adolescents may:

- 13 • Miss weeks or even months out of the school year, affecting
 14 marks and risking their promotion to the next grade;
- 15 • Have attention and memory deficits, making schoolwork a
 16 challenge and requiring special accommodations to maintain
 required academic levels;
- 17 • Become clumsy and accident prone, where once they were
 18 strong athletes; and
- 19 • Become socially withdrawn to cope with headaches and mood
 20 changes, on top of the social isolation caused by resigning from
 athletic teams.

21 7. There is an evolving body of literature showing that heading a soccer ball can result in
 22 problems of memory and attention, as well as structural and metabolic differences visible on
 23 advanced brain imaging, even in the absence of a symptomatic concussion.

24 ³ John W. O’Kane, MD; Amy Spieker, MPH; Marni R. Levy, BS; Moni Neradilek, MS;
 25 Nayak L. Polissar, PhD; Melissa A. Schiff, MD, MPH. Concussion Among Female Middle-School
 Soccer Players. *JAMA Pediatr.* 2014; 168(3):258-264. doi: 10.1001/jamapediatrics.2013.4518.

26 ⁴ Barlow KM, Crawford S, Stevenson A, et al. Epidemiology of Postconcussion Syndrome in
 27 Pediatric Mild Traumatic Brain Injury. *Pediatrics* 2010;126(2):e374 e381.

28 ⁵ Zemek, Roger et al. Guidelines for Diagnosing and Managing Pediatric Concussion. Ontario
 Neurotrauma Foundation 2014.

- A study of professional soccer players found those with more headers over a season had worse attention, visual memory, and verbal memory.⁶
- Research conducted with high school soccer players showed slower cognitive function than controls, related to how often they headed the ball.⁷
- In a recent study, 37 amateur soccer players found that as a player sustained more headers, structural brain changes and memory deficits became more pronounced.⁸
- A study comparing soccer players who had not sustained a concussion to athletes not exposed to any brain trauma (swimmers) found that the soccer players showed brain changes consistent with mild traumatic brain injury.⁹

8. There is substantial evidence that young people may be more susceptible to damage resulting from repetitive concussive and sub-concussive brain trauma. Studies in boxing, hockey, and football reveal that the earlier one is exposed to greater brain trauma, the greater their risk of long-term problems.

- A study of boxers found that for those with less education, psychomotor speed scores declined significantly with increasing years of fighting.¹⁰
- A study of college football players found a significant relationship between the number of years played and a smaller

⁶ Matser JT, Kessels AG, Lezak MD, Troost J. A dose-response relation of headers and concussions with cognitive impairment in professional soccer players. *Journal of Clinical and Experimental Neuropsychology* 2001;23:770-4.

⁷ Zhang MR, Red SD, Lin AH, Patel SS, Sereno AB. Evidence of cognitive dysfunction after soccer playing with ball heading using a novel tablet-based approach. *PloS one* 2013;8:e57364.

⁸ Lipton ML, Kim N, Zimmerman ME, et al. Soccer heading is associated with white matter microstructural and cognitive abnormalities. *Radiology* 2013;268:850-7.

⁹ Koerte IK, Ertl-Wagner B, Reiser M, Zafonte R, Shenton ME. White matter integrity in the brains of professional soccer players without a symptomatic concussion. *JAMA: The Journal of the American Medical Association* 2012;308:1859-61.

¹⁰ Banks, SJ, Obuchowski, N, Bernick, C. The Protective Effect of Education on Cognition in Professional Fighters. *Archives of Clinical Neuropsychology* 29 (2014) 54-59.

hippocampus, an area of the brain essential for creating new memories.¹¹

- In younger children, the long-term effects of brain trauma can become apparent years after injury, as normal developmental milestones are disrupted.¹²

9. There is evidence that having a strong neck may help reduce risk of concussion by reducing head acceleration caused by an impact.¹³ Younger athletes typically have weaker necks, which could put an athlete at higher risk for concussion.

- A study of adolescent soccer players performing headers in a lab showed that subjects with weaker necks sustained greater head acceleration than those with stronger necks.¹⁴
- In a study of over 6,700 high school athletes, greater neck strength was significantly correlated with reduced risk of concussion, further supporting a role of neck strength in concussion risk.¹⁵

10. Younger players are typically not provided professional medical supervision, either during practices or at matches. About half of all high schools have access to an athletic trainer, but very few have an athletic trainer present on the sidelines or on call to help identify concussions during play.

- A national study of over 100 high schools showed that schools with athletic trainers may identify up to 8 times as many concussions.¹⁶

¹¹ Singh R, Meier TB, Bellgowan PS. Relationship of collegiate football experience and concussion with hippocampal volume and cognitive outcomes. JAMA. 2014 May 14;311(18):1883-8. doi: 10.1001/jama.2014.3313.

¹² Daneshvar DH, Riley DO, Nowinski CJ, McKee AC, Stern RA, Cantu RC. Long-term consequences: effects on normal development profile after concussion. Physical medicine and rehabilitation clinics of North America 2011;22:683-700, ix.

¹³ <http://www.brainline.org/content/multimedia.php?id=9024> (visited August 9, 2014).

¹⁴ Gutierrez GM, Conte C, Lightbourne K. The relationship between impact force, neck strength, and neurocognitive performance in soccer heading in adolescent females. Pediatric exercise science 2014;26:33-40.

¹⁵ Collins CL, Fletcher EN, Fields SK, Kluchurosky L, Rohrkemper MK, Comstock RD, Cantu RC. Neck strength: A protective factor reducing risk for concussion in high school sports. J Prim Prey. 2014 Jun 15.

¹⁶ LaBella C, et al. "A comparative analysis of injury rates and patterns among girls' soccer and basketball players at schools with and without athletic trainers from 2006/07-2008/09" AAP 2012.

- A study of ice hockey teams found that by placing a doctor in the stands to look for concussions, they were able to identify 7 times more concussions than with an athletic trainer alone.¹⁷

11. Recognizing the risks associated with concussions and the accumulation of subconcussive hits in children, several other sports, but not soccer, have modified rules to limit young athletes' exposure to purposeful, repeated brain trauma. These rule changes aim to reduce concussions and sub-concussive impacts in young players, and increase focus on skill development.

- USA Hockey has eliminated checking for 11-12 year old players, introducing intentional contact at age 13.
- US Lacrosse has made all hits to the head and neck area result in a penalty.

12. Purposefully heading the ball is a legal and encouraged maneuver, and written guidelines from soccer's governing bodies recommend introducing heading at age 10. The guidelines are not widely enforced, and soccer players have reported beginning to engage in heading as young as age 3.

13. Former United States Women's National Team members Brandi Chastain, Cindy Parlow Cone, and Joy Fawcett each played in hundreds of domestic and international competitions on behalf of the United States and each won the FIFA Women's World Cup. They no longer allow the players they coach, or their own children, to head the ball before high school.

14. Soccer is played according to the "Laws of the Game." FIFA enacts the Laws of the Game and some form of these laws is then enacted by each of soccer's governing bodies. FIFA, and the other governing bodies, including the International Football Association Board (IFAB) have the power to enact and enforce Laws of the Game that would properly protect participants from concussions that are preventable, as well as properly protect participants who suffer concussions from returning to play until they have progressed through a stepwise, graded exertional return-to-play protocol and are symptom free for at least 24 hours.

¹⁷ Echlin PS, Johnson AM, Riverin S, et al. A prospective study of concussion education in 2 junior ice hockey teams: implications for sports concussion education. Neurosurg Focus 2010;29:E6.

1 15. Across the globe, the organizational hierarchy for soccer in each country including the
2 United States starts with FIFA:

3 “With control of the planet’s most popular game, soccer, and its most
4 important tournament, the World Cup, FIFA is arguably the most
5 powerful organization in sports.”

6 – Associated Press, 2010.

7 16. FIFA is headquartered in Switzerland and for decades has identified itself as “world
8 football’s governing body.”¹⁸ FIFA further identifies itself as “the guardian of this most cherished
9 game.” FIFA, however, has failed at the most basic duty of a governing body – to protect the health
10 and safety of those that are governed. There is an epidemic of concussion injuries in soccer at all
11 levels around the world, including in the United States, from youth to professionals, from elite
12 players to children playing for the first time, women and men, girls and boys. FIFA presides over this
13 epidemic, and is one of its primary causes. By this lawsuit, Plaintiffs seek to require FIFA to become
14 part of the cure.

15 17. FIFA has directly taken on the duty to protect players’ safety in regards to concussion
16 issues, and it has utterly failed in discharging that duty. Here are some of the most directly on-point
17 quotes from FIFA materials described in more detail herein:

- 18 • “For more than a decade, making football a safe sport has been
19 our major objective.”
- 20 • “As an international federation, FIFA has taken a pioneering
21 role in sports medicine.”
- 22 • “FIFA, through its Medical Assessment and Research Centre
23 (F-MARC), has been active in football medical research ever
24 since 1994, paying special attention to protecting players’
25 health, prevention, improving standards of care worldwide,
26 environmental factors as well as the education and training of
27 physicians, physiotherapists, coaches and players at all levels.”
- “FIFA has also other bodies helping to fulfill its important
mission. F-MARC aims to protect players’ health, prevent
injury and maximise the health benefits of the game.”

28 ¹⁸ The term “football” as used herein refers to what in the United States is often referred to as
“soccer,” but elsewhere in the world is referred to as “football.”

- 1 • FIFA's "Medical Committee shall deal with all medical aspects
- 2 of football."
- 3 • "We believe that we have a duty to society that goes beyond
- 4 football: to improve the lives of young people and their
- 5 surrounding communities, to reduce the negative impact of our
- 6 activities and to make the most we can of the positives."
- 7 • "As world football's governing body, we take our duty to
- 8 protect the game very seriously. Furthermore, our social
- 9 responsibility is taking on an increasingly important role and in
- 10 this, the third pillar of our mission, 'build a better future,' sends
- 11 out a strong signal. Our work to serve people, football and our
- 12 society is not simply a promise but also a duty and part of our
- 13 objective of protecting the game."
- 14 • "Played by millions around the world, football is the heart and
- 15 soul of FIFA and as the guardian of this most cherished game,
- 16 we have a great responsibility. This responsibility does not end
- 17 with organising the FIFA World Cup and the various other
- 18 world cup competitions; it extends to safeguarding the Laws of
- 19 the Game, to developing the game around the world and to
- 20 bringing hope to those less privileged."

18. Despite FIFA's pronouncements to the contrary, it has not taken appropriate actions in regards to protecting the safety of players at any level, including in the United States. One commentator has called FIFA's approach to concussion management "barbaric."

19. FIFA's influence in the U.S. is far more than merely symbolic; it is contractual. FIFA serves as the international governing body for soccer and the USSF has been a member since 1913. The USSF, along with over 209 other national soccer organizations, are members of FIFA.

20. The United States Soccer Federation, also branded by the federation as "U.S. Soccer" (hereinafter "U.S. Soccer" or "USFS"), is "the governing body of soccer in all its forms in the United States,"¹⁹ and "falls under the auspicious of the United States Olympic Committee and FIFA (Federation International de Football Association)."²⁰ U.S. Soccer is the national association member in FIFA for the United States.

¹⁹ <http://www.ussoccer.com/about/about-us-soccer>.

²⁰ <http://www.ussoccer.com/about/federation-services/sports-medicine> (last visited July 24, 2014).

21. Like many federations, U.S. Soccer has multiple “affiliates” or members consisting of youth, amateur, development, and professional leagues operating throughout the United States.²¹ “Together, local, national and international organizations form a family of support for the young soccer players of America.”²²

22. U.S. Soccer states that “[i]ts mission is to govern the sport of soccer in the United States and prepare all teams for both national and international competitions such as the Olympics, World Cup, CONCACAF Championships and international friendlies and exchanges.”²³ From the information set forth above, it is clear that U.S. Soccer serves at least two purposes – one is confined to preparing players of numerous age levels for participation in elite competitions. With regard to those top players, those selected become part of the U.S. Soccer Development Academy program with clubs across the country beginning at ages U-13 and U-14.²⁴ At the same time, however, U.S. Soccer also has a much broader stated role, encouraging millions of players including youth players of all skill levels to play soccer and make it part of a lifelong passion.

23. The US Youth Soccer Association (“USAYSA”) is an affiliate of FIFA and member of U.S. Soccer. USAYSA describes itself as the largest youth sports organization in the United States consisting of more than 3 million members between ages 5-18 or 85% of all registered soccer players in the United States. USAYSA provides “uniform rules and guidelines to its membership which comprises 55 member State Associations, 500,000 volunteers and administrators and 300,000 coaches, most of which are also volunteers.” In California, USAYSA affiliates include “Cal North” also previously referred to as CYSA North and Cal North, like the other defendants here, FIFA “Laws of the Game” apply to all competitions sponsored by Cal North and Cal South.²⁵

24. Rule 301 of the US Youth Soccer Policy On Players And Playing Rules provides in pertinent part: “Except as provided by USYSA or its State Associations, the FIFA “Laws of the

²¹ <http://www.ussoccer.com/about/about-us-soccer/organizational-structure>.

²² http://www.usyouthsoccer.org/media_kit/organizationprofile/.

²³ <http://www.ussoccer.com/about/federation-services/sports-medicine> (last visited July 24, 2014).

²⁴ <http://academy.demosphere.com>.

²⁵ <http://www.calsouth.com/en/referees/laws-of-the-game/>.

Game” apply to all competitions sponsored by USYSA.” The stated objective of USAYSA is to provide a “fun, safe and healthy game for ALL kids” and to foster the physical, mental, and emotional growth and development of America’s youth through the sport of soccer at all levels of age and competition.²⁶

25. American Youth Soccer Organization (“AYSO”) is a National Association member of the United States Soccer Federation and states that it is the oldest *national* youth soccer program in the United States. It is a non-profit organization that provides youth soccer programs at a recreational level for participants all over the United States and internationally in the Virgin Islands and Trinidad and Tobago. Consisting of over 50,000 teams and 500,000 players nationwide, it is one of the leading youth soccer organizations in the world. It is often called “the biggest soccer club in the world.”²⁷ Each player that chooses to play on an AYSO team must have a game card reflecting eligibility.

26. As required by FIFA and US Soccer, AYSO enforces the FIFA Laws of the Game (AYSO ed.). The FIFA Laws of the Game (AYSO ed.) provide: “[T]he International Football Association Board reminds the associations and confederations that it is their duty, under the FIFA Statutes, to ensure the Laws of the Game are implemented strictly and consistently at all levels of competition.”

27. US Club Soccer (“US Club”) is an organization committed to the development and support of soccer clubs in the United States, including in this judicial district. Through US Club, all of a club’s programs are able to be united under one organizational umbrella, creating a “members for life” culture within each club. US Club’s mission is to improve the level of play of the competitive soccer player, and thereby the U.S. National Teams and professional leagues.²⁸ US Club hosts a variety of levels of competitions, including competitions for elite and aspiring athletes that desire to play soccer at a high level, including the ability to attract the attention of colleges. Policy

²⁶ *Id.*

²⁷ http://www.ayso.org/aboutayso/What_is_AYSO_.htm?PageMode=Print (last visited Aug. 7, 2014).

²⁸ <http://www.usclubsoccer.org/about/mission-philosophy/> (last visited Aug. 7, 2014).

1 8.04 of US Club Soccer Policies provides: “As a general rule, FIFA Laws of the Game shall be the
2 competition rules that apply to all competitive team games.”

3 28. Each of these associations has failed to adopt and enforce Laws of the Game that
4 would reduce the risk of preventable injuries resulting from concussions and repetitive heading.

5 29. First, each has failed to enact and/or enforce best practices for concussion
6 management.

7 30. Second, FIFA has also failed to modify the Laws of the Game to provide proper
8 protection from concussion injuries in two aspects. First, FIFA has strict rules about the number of
9 players that can be substituted. These strict rules do not allow a team to take a potentially concussed
10 player out of a game solely for evaluation. As a result, teams leave in concussed players who are
11 placed at risk for aggravating brain injuries that would resolve had they been evaluated and removed
12 from the game. FIFA’s failure in this regard has caused leagues lower in the hierarchy either to limit
13 substitution or to not emphasize in their Laws of the Game the mandate to substitute for concussion
14 evaluation.

15 31. Third, youth players are particularly vulnerable to brain injury from heading. There
16 exists state of the art medical evidence indicating that players under the age of 17 should not take
17 headers in practice or be limited in the number per week, and that players under 14 should not head
18 at all, or at a minimum be limited in the number of headers.

19 32. Plaintiffs, on behalf of themselves and a proposed class of all current or former soccer
20 players who, from 2002 to the present, competed for a team governed by FIFA, the United States
21 Soccer Federation, US Youth Soccer, American Youth Soccer Organization, or US Club Soccer,
22 seek injunctive relief requiring enactment of Laws of the Game that provide proper concussion
23 management and return-to-play guidelines. Plaintiffs thus seek an injunction requiring each
24 Defendant to (1) mandate the enactment and enforcement of proper concussion-management
25 practices and return-to-play guidelines; (2) mandate substitution rules that allow for medical
26 evaluation without penalty; and (3) mandate limits on heading by players under 17.

II. JURISDICTION AND VENUE

33. This Court has original jurisdiction pursuant to 28 U.S.C. § 1332(d)(2). In the aggregate, Plaintiffs' claims and the claims of the other members of the Class exceed \$5,000,000 exclusive of interest and costs, and there are numerous class members who are citizens of states other than each Defendant's states of citizenship.

34. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b)(1), 28 U.S.C. § 1391(b)(2), and 28 U.S.C. § 1391(c) as each Defendant is deemed to reside in this judicial district because it is subject to personal jurisdiction here, a substantial part of the events and/or omissions giving rise to the claims emanated from activities within this jurisdiction, and each Defendant conducts substantial business in this jurisdiction.

35. All Defendants are subject to personal jurisdiction in this District. Each defendant has the requisite minimum contacts with California so as to be subject to both types of personal jurisdiction – general jurisdiction and specific jurisdiction. As discovery will further establish, all Defendants' contacts have been continuous and systematic over a significant period of time and throughout the Class Period. As described herein, Defendants' actions and omissions have caused harm in California to California residents, including minors, and will continue to do so unless enjoined, thus establishing specific personal jurisdiction. Moreover, Defendants have had substantial, continuous, and systematic other contacts with California, thus establishing general jurisdiction.

36. Northern California is home to the largest concentration of youth soccer players in the country. For example, Defendant USYS on its website provides a state-by-state breakdown of members in each state "as of the 2011/2012 seasonal year." California is split into two regions – Northern and Southern. Northern California is listed as having more members – 171,267 – than any other State or region in the country.

37. The largest state youth soccer association is headquartered in this District in Pleasanton, California. The California Youth Soccer Association, also known as Cal North or "CYSA," serves Northern California. It states on its website that "[s]ince its first year of inception in 1969, with membership numbers just topping 100,000, CYSA has grown to be the largest state youth

soccer organization in the United States, counting more than 188,00 members ages 5-19.” CYSA emphasizes numerous Defendants’ control over it, stating that “CYSA is a member of a much larger soccer community, and therefore its players are members of this world community.” CYSA continues that “[b]oys and girls register to play with one of the more than 300 clubs or leagues formed by CYSA” in Northern California. CYSA further states that “[e]ach of the nine districts are CYSA and therefor members of US Youth Soccer and US Soccer. US Soccer, along with over 197 other national soccer organizations, are members of FIFA, the Federation Internationale de Football Association. FIFA serves as the international governing body for soccer and US Soccer has been a member since 1913.” CYSA continues that “[t]ogether, local, national and international organizations form a family of support for the young soccer players of CYSA.”

III. PARTIES

A. Plaintiffs

38. Plaintiff Rachel Mehr is a natural person and resides in Novato, California. Individually and on behalf of the Class, Ms. Mehr is suing FIFA, AYSO, US Youth Soccer Association and US Club Soccer, as she played for teams that were members of and governed by USYSA and US Club Soccer. Ms. Mehr played in competitions hosted by USYSA and US Club Soccer, including tournaments which occurred in this judicial district.

39. Pursuant to Section 1 of Rule 301 of US Youth Soccer Policy On Players And Playing Rules: “Except as provided by USYSA or its State Associations, the FIFA “Laws of the Game” apply to all competitions sponsored by USYSA.” USYSA has not instituted any rules with respect to concussion management, return-to-play guidelines or limitations on heading that differ in any material respects from FIFA. Likewise, Policy 8.04 of US Club Soccer Policies provides: “As a general rule, FIFA Laws of the Game shall be the competition rules that apply to all competitive team games.” US Club Soccer has not instituted any rules with respect to concussion management, return-to-play guidelines or limitations on heading that differ in any material respects from FIFA.

40. Ms. Mehr is at increased risk of latent brain injuries caused by repeated head impacts as well as the accumulation of concussive and subconcussive hits in her soccer career and therefore

1 is in need of medical monitoring. Further, on behalf of the Class, Ms. Mehr seeks class-wide
 2 injunctive or equitable relief in the form of changes to FIFA, USYSA, and US Club Soccer rules and
 3 practices with respect to concussion management, return-to-play guidelines, and limitations on
 4 heading in order to meet consensus best practices as detailed below.

5 41. Plaintiff Beata Ivanauskiene (“Mrs. Ivanauskiene”), as parent of minor R.K.I. Jr.
 6 (“R.K.I.”), is suing FIFA and USYSA on behalf of R.K.I. and the Class. Mrs. Ivanauskiene and
 7 R.K.I. are residents of Antioch, Illinois. R.K.I. was born in 2003, and is currently 10 years old. R.K.I.
 8 is playing and has played soccer in the Young Sportsmen’s Soccer League in Arlington Heights,
 9 Illinois for the last three years.

10 42. As required by the US Youth Soccer Policy On Players And Playing Rules, the
 11 Young Sportsmen’s Soccer League is a member of the Illinois Youth Soccer Association, which is a
 12 member of the US Youth Soccer Association (“USYSA”). Thus, the Young Sportsmen’s Soccer
 13 League must and does abide by the “FIFA Laws of the Game,” except as provided by USYSA or the
 14 Illinois Youth Soccer Association.²⁹ The Illinois Youth Soccer Association has not instituted any
 15 rules with respect to concussion management, return-to-play guidelines, or limitations on heading
 16 that differ in any material respects from FIFA or USYSA.

17 43. R.K.I. is at increased risk of latent brain injuries caused by repeated head impacts or
 18 the accumulation of subconcussive hits, particularly as a minor, in his soccer career and therefore is
 19 in need of medical monitoring. Further, on behalf of her minor son and the Class, Mrs. Ivanauskiene
 20 seeks class-wide injunctive or equitable relief in the form of changes to FIFA and USYSA rules and
 21 practices with respect to concussion management, return-to-play guidelines, and limitations on
 22 heading in order to meet consensus best practices as detailed below.

23 44. Plaintiff Sarah Aranda (“Mrs. Aranda”), as parent of minors B.A., D.A., and I.A., is
 24 suing FIFA, USSF, and AYSO on behalf of her minor children and the Class. Mrs. Aranda and B.A.,
 25 D.A., and I.A. are residents of DeKalb, Illinois. B.A. was born in 2003, and is currently 11 years old.

26
 27 ²⁹ Rule 301, US Youth Soccer Policy On Players And Playing Rules (as of September 1, 2013),
 28 available at <http://www.usyouthsoccer.org/aboutus/DownloadCenter/?CategoryId=124> (last accessed
 August 15, 2014).

1 D.A. was born in 2005, and is currently eight years old. I.A. was born in 2007, and is currently seven
2 years old. B.A., D.A., and I.A. played AYSO soccer in DeKalb, Illinois.

3 45. AYSO is a National Association member of the United States Soccer Federation. As
4 required by FIFA, USSF, and AYSO, the AYSO teams in DeKalb, Illinois follow the FIFA Laws of
5 the Game (AYSO ed.). In fact, the FIFA Laws of the Game (AYSO ed.) expressly provide: “[T]he
6 International Football Association Board reminds the associations and confederations that it is their
7 duty, under the FIFA Statutes, to ensure the Laws of the Game are implemented strictly and
8 consistently at all levels of competition.” AYSO considered a complete ban on heading due to the
9 associated risk but after internal debate failed to do so. To date, it has “discouraged” children under
10 10 to not head the ball. But AYSO has not instituted any rules with respect to concussion
11 management, return-to-play guidelines or limitations on heading that differ in any material respects
12 from FIFA or USSF. AYSO has also failed to institute proper instructions to its parent coaches on
13 proper heading techniques and drills thereby sometimes increasing the risk of injury.

14 46. B.A., D.A., and I.A. are at increased risk of latent brain injuries caused by repeated
15 head impacts or the accumulation of subconcussive hits, particularly as minors, in their soccer
16 careers and therefore are in need of medical monitoring. Further, on behalf of her minor sons and
17 daughter and the Class, Mrs. Aranda seeks class-wide injunctive or equitable relief in the form of
18 changes to FIFA, USSF, and AYSO rules and practices with respect to concussion management,
19 return-to-play guidelines, and limitations on heading in order to meet consensus best practices as
20 detailed below.

21 47. Kira Akka-Seidel is a natural person, a citizen of the state of California, and resides at
22 Larkspur, California. Ms. Akka-Seidel last competed in soccer during the 2013 season for the
23 University of California at Santa Cruz women’s club side and will be returning to college this fall.
24 That team competes under FIFA Laws of the Game. Previously, prior to entering college, Ms. Akka-
25 Seidel played soccer for the Mill Valley Soccer Club, which was affiliated with both USYSA and US
26 Club Soccer. Ms. Akka-Seidel played for Tiburon Peninsula Soccer Club, which is “an affiliated
27 branch of and compl[ies] with the authority of Cal North, also referred to as the California Youth
28 Soccer Association, Inc. (CYSA), CYSA sanctioned programs, the United States Youth Soccer

1 Association (USYSA), and/or the United States Soccer Federation (USSF).”³⁰ Individually and on
 2 behalf of the Class, Ms. Akka-Seidel is suing FIFA, USYSA, and USSF Soccer.

3 48. As required by the US Youth Soccer Policy On Players And Playing Rules, the
 4 Tiburon Peninsula Soccer League is a member of the California Youth Soccer Association, which is
 5 a member of USYSA. Thus, the Tiburon Peninsula Soccer League must and does abide by the “FIFA
 6 Laws of the Game,” except as provided by USYSA or the California Youth Soccer Association.³¹
 7 Cal North does have a Concussion Procedure and Protocol, but it does not comply with consensus
 8 best practices. Moreover, the California Youth Soccer Association, which was founded in 1969 and
 9 now has branded itself as Cal North, has not instituted any rules with respect to limitations on
 10 heading that differ in any material respects from FIFA or USYSA. The same is true of Cal South,
 11 previously known as California Youth Soccer association South.

12 49. Ms. Akka-Seidel is at increased risk of latent brain injuries caused by repeated head
 13 impacts or the accumulation of concussive and/or subconcussive hits in her soccer career and
 14 therefore is in need of medical monitoring. Further, on behalf of the Class, Ms. Akka-Seidel seeks
 15 class-wide injunctive or equitable relief in the form of changes to FIFA, USSF, USYSA, rules and
 16 practices with respect to concussion management, return-to-play guidelines, and limitations on
 17 heading in order to meet consensus best practices as detailed below.

18 50. Karen Christine O’Donoghue (“Ms. O’Donoghue”), as parent of minor L.L.M. is
 19 suing FIFA, USSF and AYSO on behalf of L.L.M. and the Class. Ms. O’Donoghue and L.L.M. are
 20 residents of Longmont, Colorado. L.L.M. is currently 17 years old. She played soccer for the
 21 Boulder Force Club.

22 51. As required by the US Youth Soccer Policy On Players And Playing Rules, the
 23 Boulder Force Club was a member of the Colorado Soccer Association, which is a member of the US
 24 Youth Soccer Association (“USYSA”). Thus, the Boulder Force Club must and did abide by the

25
 26 ³⁰ See Tiburon Peninsula Soccer Club Constitution, available at
http://www.tiburonsoccer.org/About_TPSC/Rules/index_E.html (last accessed August 22, 2014).

27 ³¹ Rule 301, US Youth Soccer Policy On Players And Playing Rules (as of September 1, 2013),
 28 available at <http://www.usyouthsoccer.org/aboutus/DownloadCenter/?CategoryId=124> (last accessed
 August 15, 2014).

1 “FIFA Laws of the Game,” except as provided by USYSA or the Colorado Soccer Association.³²
 2 The Colorado Soccer Association has not instituted any rules with respect to concussion
 3 management, return-to-play guidelines, or limitations on heading that differ in any material respects
 4 from FIFA or USYSA.

5 52. L.L.M. is at increased risk of latent brain injuries caused by repeated head impacts or
 6 the accumulation of subconcussive hits, particularly as a minor, in her soccer career and therefore is
 7 in need of medical monitoring. For example, L.L.M. suffered a concussion in 2013 during a soccer
 8 game while she played for the club, Boulder Force. L.L.M. was hit in the head when someone kicked
 9 the ball and fell to the ground. However, she was returned to play in the same game and headed a
 10 ball into the goal. She went home, and slept the rest of the weekend with a headache. She then
 11 missed school, experiencing headaches, dizziness, and mental fuzziness. As a result of the
 12 concussion, L.L.M. experienced daily headaches for six months. Accordingly, she is in need of
 13 medical monitoring.

14 53. Further, on behalf of her minor daughter and the Class, Ms. O’Donoghue seeks class-
 15 wide injunctive or equitable relief in the form of changes to FIFA, USSF, and USYSA rules and
 16 practices with respect to concussion management, return-to-play guidelines, and limitations on
 17 heading in order to meet consensus best practices as detailed below.

18 54. Plaintiffs, as described herein, have been damaged by the actions and inactions of
 19 each of the Defendants.

20 **B. Defendants**

21 **1. FIFA.**

22 55. Defendant Fédération Internationale de Football Association, also known as “FIFA,”
 23 identifies itself in its governing “Statutes” as “an association registered in the Commercial Register
 24 in accordance with art. 60 ff. of the Swiss Civil Code.”
 25
 26

27 ³² Rule 301, US Youth Soccer Policy On Players And Playing Rules (as of September 1, 2013),
 28 available at <http://www.usyouthsoccer.org/aboutus/DownloadCenter/?CategoryId=124> (last accessed
 August 15, 2014).

1 56. FIFA is subject to specific and general personal jurisdiction in this District. As
2 described herein, it exerts massive worldwide influence and regulation over all aspects of soccer,
3 including in the United States and in California. Moreover, FIFA engages in a broad swath of
4 commercial activities in the U.S. and in California, strategically reinforcing its “brand” and its
5 primacy in the world of soccer and entrenching its influence. FIFA has extracted, and continues to
6 extract, massive sums of money from the U.S. and California, and has not contributed to protecting
7 the safety of the youth players to which it markets and influences. To illustrate only one example,
8 most recently in August 2014, Dick’s Sporting Goods has implemented television advertisements
9 entitled “Corner Kick” showing high school soccer players from Ramapo High School jostling and
10 pushing to head using a FIFA-branded World Cup 2014 soccer ball during domestic competition in
11 the United States.

12 57. FIFA’s media bombardment has continued unabated throughout the Class Period.
13 FIFA has entered into numerous licensing and distribution agreements with companies
14 headquartered in California, such as Electronic Arts Inc. (“EA”), Apple Computer Inc., and Google
15 Inc. / YouTube. FIFA also has entered into numerous licensing agreements with companies relating
16 to products specifically intended to be sold and distributed in California. Numerous of FIFA’s
17 licensing and distribution agreements are for products that specifically target the youth market, such
18 as the FIFA franchise video-games, youth soccer balls, children’s apparel, stuffed animals, and
19 stickers. The FIFA franchise is the best-selling sports video game franchise ever, and one of the best-
20 selling video game franchises in the world, including in California. In this video game, heading of
21 the ball provides in-game rewards as well as training exercises. None of the FIFA games advise of a
22 risk to players if done incorrectly or at an inappropriate age even though FIFA and the creator of the
23 franchise are well aware of the immense influence that video games have on youth of all ages.

24 58. More examples of FIFA’s contacts with California follow. On April 14, 2014, FIFA’s
25 business partner Coca-Cola issued a press release and stated “Coca-Cola and FIFA are bringing the
26 world’s most celebrated trophy to the United States ... The tour arrives on U.S. soil this week. The
27 FIFA World Cup Trophy by Coca-Cola will visit four cities across the nation ... [including] Los
28 Angeles ...” Coca-Cola continued that “the FIFA World Cup Trophy will visit Los Angeles for a

1 two-day Coca-Cola Fan Fest at L.A. Live.” Coca-Cola continued that it “also will introduce special
2 limited-edition FIFA World Cup-branded bottles, fridge packs and collectible can designs.” Coca-
3 Cola directed interested persons to visit FIFA’s website to learn more about the tour.

4 59. In 2011, FIFA sponsored in California the finals of its “FIFA Interactive World Cup
5 2011,” a worldwide FIFA videogame competition that FIFA extensively promotes and details
6 including on its website. FIFA stated in a 2011 press release that “[t]his year’s Grand Final takes
7 place from 7-9 June in Los Angeles.”

8 60. On December 13, 2007, FIFA issued a press release titled “California group joins
9 FIFA fold,” and stated that FIFA “has decided to set-up further FIFA Medical Centres of Excellence
10 across all continents to ensure that players have access to high quality football medicine ... On 10
11 December 2007, Jiri Dvorak, FIFA’s Chief Medical Officer and Chairman of the FIFA Medical
12 Assessment and Research Centre (F-MARC), officially presented Dr. Bert Mandelbaum, director,
13 with the official accreditation certificate for the Santa Monica Orthopaedic and Sports Medicine
14 Group.” Dr. Mandelbaum is located in California and currently serves on two FIFA committees, the
15 Medical Committee, and F-Marc.

16 61. In 2003, FIFA hosted in the United States the Women’s World Cup, and one of the
17 six venues was in Los Angeles, California. Numerous matches were played in California, including
18 the Final. In 2006, a facility at Carson, California split the hosting of the Women’s World Cup
19 qualifying tournament with Miami, Florida.

20 62. Moreover, FIFA has repeatedly availed itself of the benefits and privileges of utilizing
21 for its benefit the judicial system in the United States. For example, FIFA sued alleged copyright and
22 trademark infringers in California in 2003. FIFA has additionally instituted litigation in other federal
23 courts around the country. As FIFA wrote to a federal court in Oregon in 2003, in a case in which it
24 was a plaintiff, FIFA “has widely distributed throughout the United States, including this District,
25 authorized and licensed goods and merchandise bearing FIFA copyrights and trademarks.” FIFA
26 continued that “[g]enuine goods and merchandise bearing FIFA World Cup copyrights and
27 trademarks have been advertised to the purchasing public and to the trades throughout the United
28 States, including this District, on an extensive and frequent basis through a variety of advertising

1 media, including newspapers, magazines, television, radio and various trade publications.” The same
2 holds true with respect to FIFA’s activities in this District.

3 63. FIFA also has entered into massive broadcasting and advertising/ branding
4 agreements relating to the U.S. market including the enormous California market. For example,
5 ESPN.com reported on October 11, 2011 that “FIFA cashed in on a \$1.2 billion bonanza from
6 United States broadcasters Friday, striking World Cup deals with Fox, Telemundo and Spanish
7 language radio. Fox won the English-language U.S. television rights for the 2018 and 2022
8 tournaments, outbidding incumbent ESPN and NBC for soccer’s showpiece tournament. Fox agreed
9 to pay around \$425 million for the two-tournament package, a person familiar with the bidding told
10 The Associated Press ...”

11 64. On October 2, 2005, FIFA issued a press release titled “ABC/ESPN and UNIVISION
12 awarded US TV rights for all FIFA events from 2007 to 2014,” and stated that “[t]he two networks
13 have been awarded the TV rights to all FIFA events for the US territory from 2007 to 2014 including
14 the two FIFA World Cup™ final competitions within this period. This impressive new agreement
15 covers a wide range of media categories, including multimedia broadband internet and mobile
16 telephony.” FIFA continued that “[t]he agreement represents the biggest TV deal in a single country
17 in FIFA's history, consisting of a record cash payment of USD 425 million from the broadcasters for
18 all FIFA events.” FIFA’s press release further emphasized the advertising and promotional value of
19 the deal, stating that “[i]n addition to the cash amount, ABC/ESPN and UNIVISION will run
20 substantial promotions for FIFA events and the FIFA brand across the USA during the entire period
21 of the contract.” FIFA continued that “ESPN’s extensive network of cooperation – in particular with
22 other commercial affiliates such as [California-based] Electronic Arts – will support the cross-
23 promotion of football and FIFA’s assets across the USA using a variety of channels entirely in line
24 with FIFA's stated mission.” FIFA continued that the agreement would “also promote football and
25 the FIFA brand even at those times when no tournaments are taking place.”

26 65. In Electronic Arts Inc.’s (“EA”) SEC Form 10-K, filed May 21, 2014, California-
27 based EA confirmed the massive impact that its video-game licensing agreement with FIFA has on
28 EA, and stated that “[i]n fiscal year 2014, revenue from sales of FIFA 14 represented approximately

1 15 percent of our total net revenue.” In a press release dated May 8, 2013, FIFA stated that “[t]he
2 FIFA videogames are a key experiential component in our work to communicate the FIFA brand and
3 its values all over the world.”

4 66. For sale in Toys-R-Us toy stores and other stores around the country, including in this
5 District, is a product called “2014 FIFA World Cup Brasil Official Licensed Sticker Album.” The
6 product states that it is “[m]anufactured under licence [sic] by Panini” and that Panini America Inc.,
7 based in Irving, Texas, is the “Exclusive Distributor for USA, and that the product is “Printed in the
8 USA.” The back cover reaffirms that the product is a “FIFA World Cup Brasil Official Licensed
9 Product.” FIFA encourages children to “experience the online album:
10 www.FIFA.com/stickeralbum,” and FIFA specifically directs the children to FIFA’s website. FIFA
11 further directs children to FIFA’s website for the “FIFA Quality Programme for Footballs
12 www.FIFA.com/Quality.”

13 67. FIFA runs full-page, color advertisements in the sticker book for itself. For example,
14 one states “All in One Rhythm ... with the official mascot of the 2014 FIFA World Cup Brazil” and
15 then features a cartoon animal named “Fuleco” holding a soccer ball. The next page features another
16 full-page FIFA advertisement, featuring a picture of a child dribbling a soccer ball, and the
17 advertisement copy read “Develop the Game,” “Touch the World,” “Build a Better Future,” and
18 “FIFA For the Game. For the World.” Another full-page, color advertisement encourages children to
19 visit FIFA’s website to “[s]ee the range online at: www.FIFA.com/store” and also encourages them
20 to visit FIFA’s website at www.FIFA.com/stickeralbum. Another full-page, color advertisement
21 states at the top in large type “FIFA.com Putting You At The Heart of The Game.” FIFA continues:
22 “Be at the heart of the action during Brazil 2014 – anywhere, anytime – following it all with
23 FIFA.com, the FIFA App, FIFA on YouTube, as well as on Twitter and Facebook.” Another full-
24 page, color advertisement states at the top in large type “visit www.FIFA.com/store today” and then
25 FIFA displays numerous FIFA t-shirts, a FIFA stuffed animal, FIFA’s EA video-game, a FIFA
26 sticker book, a FIFA-branded Adidas soccer ball, and a toy FIFA trophy.

27 68. In FIFA’s “Official FIFA Online Store,” FIFA states “[p]lease see below for the list
28 of countries where FIFA.com/Store is currently shipping” and specifically identifies the “United

States” as one of those countries. FIFA further states under “Who we are”: “Welcome to The Official FIFA Store Online Store which is owned by FIFA and operated by Sports Endeavors Inc. (SEI) located at 431 US Highway 70A East Hillsborough, North Carolina.” Another section of FIFA’s Online Store states that “We welcome orders by phone, fax, or mail ... By mail: Mail to FIFA STORE Mail Order, Attn: Source Code 7FIFA, 431 US Hwy 70A East, Hillsborough, NC 27278-9334 USA. Please be sure to include your credit card number on your printed order form or enclose a check or money order payable in US dollars.”

69. FIFA’s Online Store further includes sections for “Kids,” “Balls,” and “Art and Collectibles.” Customers can also “Shop by Country,” and select “USA” among other countries. The “USA” subcategories include “Junior Women,” “Youth (Ages 7-12),” “Kids (Ages 4-7) and “Accessories & Souvenirs.” The subcategories contain a wide-variety of FIFA-branded apparel for sale, including items bearing the image of FIFA’s cartoon character mascot.

70. FIFA further sells via its website EA’s FIFA videogames, and a bevy of other FIFA-branded merchandise, including stuffed animals, hats including one modeled after FIFA’s cartoon character mascot, baby bibs, decals, miniature foosball table games, soccer balls, posters, bracelets, keychains, phone accessories, and pennants.

71. FIFA also has authorized agents in the Northern District of California. FIFA authorizes persons to act as “match” agents who have the authority to arrange for matches between FIFA-sanctioned teams. FIFA match agents in this district include Alejandro Gutman whose business address is 79 Water Street, San Francisco and Ali Koushanfar, 1450 Sutter Street, San Francisco.

2. U.S. Soccer.

72. The United States Soccer Federation, Inc., founded in 1913, also known as “USSF” or “U.S. Soccer,” is the governing domestic entity in the United States. It is the official federation which is a member of FIFA.

73. USSF has its principal place of business in Chicago, Illinois located at the “U.S. Soccer House,” 1801 South Prairie Avenue, Chicago, Illinois.

74. USSF is subject to specific and general personal jurisdiction in this District. As described herein, USSF exerts tremendous influence over all aspects of soccer in the United States and heavily regulates American soccer. Moreover, USSF has sought and received permission from the California Secretary of State (“S.O.S.”) to do business in California, and the S.O.S.’s website shows that USSF has been authorized to conduct business in California since at least as early as 2007. USSF has repeatedly held its Board of Directors meetings in Los Angeles, for example, on December 1, 2012, November 20, 2011, and February 23, 2007. Within the soccer community, it is commonly understood that the StubHub Center in Carson, California operates as a training center not just for members of the Women’s and Men’s National Teams but also for the development of youth players aspiring to play one day for the national team.

75. The StubHub Center, which is also home to the LA Galaxy and Chivas USA of the MLS, is an outdoor athletic competition arena and training facility located in California. Its website states: “Since the facility opened in 2003, StubHub Center has been the National Training Center for the U.S. Soccer Federation, hosting training camps and competition for all U.S. Soccer programs, from the U.S. U-14 Boys and Girls up to the full National Teams. The facility also regularly hosts referee training, coaching courses and other USSF events.” Youth instruction and competitions at this facility – including for the U.S. Development Academy – are conducted under FIFA Laws of the Game and include intensive training on heading of soccer balls.

76. USSF has consistently staged and promoted soccer events in this District, e.g., in San Francisco and San Jose. For example, on May 27, 2014, USSF staged at Candlestick Park in San Francisco a match between the U.S. men’s national team and the national team of Azerbaijan, as a part of USSF’s “2014 FIFA World Cup Send Off Series.” In October 2013, USSF staged in San Francisco a match between the women’s national team and the New Zealand national team. In July of 2007, USSF staged in San Jose a match between the women’s national team and the national team of Japan. In June of 2007, USSF staged in San Jose a match between the men’s national team and the national team of China. In June 2006, USSF staged in San Jose a match between the U.S. men’s national team and the national team of China. In February of 2006, USSF staged at SBC Park (now

1 AT&T Park) in San Francisco a match between the U.S. men's national team and the national team
2 of Japan.

3 **3. US Youth Soccer.**

4 77. Defendant US Youth Soccer Association, Inc., also known as "USAYSA," identifies
5 itself as the largest member of the United States Soccer Federation. USAYSA's National Office is
6 located at 9220 World Cup Way, Frisco, Texas 75033.

7 78. USAYSA is subject to specific and general jurisdiction in this District. USAYSA, in
8 the section of its website titled "Find a US Youth Soccer Club," lists at least 168 member clubs in
9 California. Each club in California in turn is composed of numerous teams. USAYSA recognizes the
10 vast number of California soccer players under its control, and the distinctiveness of California's two
11 member associations, stating that "US Youth Soccer is made up of 55 member State Associations;
12 one in each state, and two in California, New York, Ohio, Pennsylvania and Texas." USAYSA
13 further recognizes the importance of California to USAYSA, even naming a division after California,
14 and stating that "[t]he US Youth Soccer Far West Regional League is the premier league competition
15 for US Youth Soccer's Region IV (Far West), and is divided into three geographic divisions
16 (California, Desert and Northwest)."

17 79. USAYSA also conducts tournaments throughout California. For example, on June 11,
18 2014, USAYSA issued a press release and stated that "[t]he 2014 US Youth Soccer Region IV
19 Presidents Cup is now underway in Morgan Hill, Calif. The five day tournament ... features 130 US
20 Youth Soccer teams from US Youth Soccer Region IV (West) competing for a regional title ..."

21 80. USAYSA also routinely contracts with California businesses. For example, USAYSA
22 advertises on its website the "Wilson Trophy Company," headquartered in Sacramento, California,
23 as being "[t]he Official Awards Supplier for US Youth Soccer." USAYSA also advertises on its
24 website the company SKLZ as being "The Official Player Performance Sponsor of US Youth
25 Soccer." SKLZ is headquartered in Carlsbad, California. Other advertisers on USAYSA's
26 "Marketplace" section of its website include Impact Canopies USA, headquartered in Corona,
27 California, and Tritera, Incorporated, headquartered in San Diego, California.

1 81. USAYSA advertises on its website its “US Youth Soccer Shop” where visitors
 2 including from the enormous California market can purchase on-line “playing and coaching gear –
 3 from apparel to cleats to training DVDs to field equipment.” USAYSA also consistently advertises in
 4 California, including through publication and distribution of its “US Youth Soccer Fuel Soccer”
 5 magazine, which it distributes including via hard copies, via USAYSA’s website, and via Apps for
 6 the iPhone and iPad.

7 **4. AYSO.**

8 82. Defendant American Youth Soccer Organization, also known as “AYSO,” identifies
 9 itself as one of the leading youth soccer organizations in the world and they indicate that they are
 10 often called “the biggest soccer club in the world.” Each player that wishes to play on an AYSO
 11 team must fill out paperwork and receive a player card which verifies the player’s identity and age
 12 group. AYSO’s National Office is located at 19750 South Vermont Avenue, Suite 200, Torrance,
 13 California 90502. AYSO, through its acts and omissions as set forth herein, has damaged Plaintiffs
 14 and Class Members.

15 83. AYSO is subject to specific and general personal jurisdiction in this District. AYSO is
 16 headquartered in Torrance, California, and has been authorized by the California Secretary of State
 17 to do business in California since at least as early as 1967. AYSO states on its website that “[t]he
 18 AYSO National Office, located in Torrance, Calif., provides support to Regions, Areas, Sections and
 19 the National Board of Directors. The 50 National Office staff members are here to support AYSO
 20 programs and answer any questions AYSO families may have.” AYSO continues that the National
 21 Office in Torrance “provides a professional staff able to provide members with answers and
 22 solutions” and that from its headquarters “[t]he National Office provides professional: “Educational
 23 resources,” “Centralized accounting and registration functions,” “Marketing and fundraising
 24 assistance,” “Communications resources,” and “Development support.” In June and July of this year,
 25 AYSO held in Torrance and Riverside its “National Games” which AYSO stated was “expected to
 26 include over 500 teams for a week of competitive soccer, exciting youth and volunteer events, and
 27 more.”
 28

1 84. AYSO also operates and maintains in California its “AYSO Store,” a physical
2 location in Torrance, and AYSO states that the store “has proven to be a leader in supplying
3 organizations with their Custom Silkscreen and Embroidery needs providing a valuable resource for
4 tournaments, staff recognition, events and gifts. In addition to filling this need, The AYSO Store has
5 grown into an industry leader in providing top-quality field equipment like goals, corner flags and
6 training equipment.” AYSO also operates an on-line version of its store.

7 **5. US Club Soccer.**

8 85. Defendant National Association of Competitive Soccer Clubs, Inc. d/b/a “US Club
9 Soccer,” identifies itself as an organization committed to the development and support of soccer
10 clubs in the United States. Each player that wishes to play on a US Club team must fill out
11 paperwork and receive a player card which verifies the player’s identity and age group. US Club
12 Soccer’s National Office is located at 192 East Bay Street, Suite 301, Charleston, South Carolina
13 29401. Further details on US Club Soccer are set forth herein. US Club Soccer, through its acts and
14 omissions as set forth herein, has damaged Plaintiffs and Class Members.

15 86. USCS is subject to specific and general personal jurisdiction in this District. USCS
16 has ample and consistent contacts with California. For example, US Club Soccer is organized under
17 the laws of the State of California, maintains in California an agent for service of process, and has
18 been an active California corporation since at least as early as 2001. The Chairman of USCS’s Board
19 of Directors, an attorney named Phil Wright, resides and works in this State in or around Sacramento
20 and conducts USCS business from that location. Another of USCS’s nine member Board of
21 Directors, Shawn Blakeman, is one of the two representatives of USCS’s “West Region” on the
22 Board and resides and works in or around Sacramento and conducts USCS business from that
23 location.

24 87. USCS has consistently held competitions and training camps in California. For
25 example, USCS, in a section of its website titled “State Championships” states that “US Club
26 Soccer’s state championships competitions allow clubs to develop a format as they see best in their
27 respective state ...” USCS includes a link to the “NorCal State Cup.” USCS further states that “[t]he
28 NorCal State Cup is US Club Soccer’s state championship event for member teams in the U-9

1 through U-18/19 boys and girls age groups.” USCS, in a press release dated May 16, 2014 titled
2 “National Cup XIII Web series Part 1: What is US Club Soccer’s National Cup?” stated that “[i]n
3 less than a month, the National Cup XIII gets underway with its first Regional event in California.”
4 In another press release dated June 27, 2014, USCS stated that “[a] week after the region’s boys
5 teams battled for supremacy, the National Cup XIII West Regional (girls) took over Davis, Calif.,
6 June 21-24, with additional impressive, championship performances.” USCS went on to list the
7 winning girls’ clubs, almost all from California, in separate age groups for each year from “U-11”
8 through “U-17.”

9 88. USCS partners with and contracts with California entities. For example, USCS on
10 August 13, 2014, issued a press release titled “US Club Soccer’s NPL Partners with Surf Cup and
11 Jefferson Cup” and stated “US Club Soccer is proud to announce a new partnership with the Surf
12 Cup in San Diego, Calif. ..., to provide top NPL teams slots at both events in 2015. These
13 prestigious national tournaments will complement the existing US Club Soccer NPL Showcase
14 events to launch the NPL Showcase Series.” USCS continued that “[c]reated in 1981 and entering its
15 35th year, the Surf Cup has grown to become one of the top college showcases in the country. More
16 than 400 college coaches and scouts have attended each year since its inception.”

17 89. USCS also states that “[e]stablished in 2004, US Club Soccer’s id2 National
18 Identification and Development Program provides an opportunity for the country’s elite youth soccer
19 players to be identified and developed, and scouted for inclusion in U.S. Soccer’s National Team
20 programs.” In an article titled “Second Spring 2012 id2 Program Training Camp concludes in Irvine,
21 Calif.,” soccerwire.com reported on April 23, 2013, that “[t]he second and final Spring 2012
22 id2Program Training Camp concluded Sunday, as a total of 120 elite boys born in 1998-99 and girls
23 born in 1997-98 from 23 states wrapped up four days of high-level training and matches at the
24 University of California-Irvine.” USCS has repeatedly held such training camps in Irvine, California,
25 for example, in 2007 and 2006.

26 90. USCS has advised California entities and entered into financial arrangements with
27 them. For example, Northern California’s “NorCal Premier Soccer” club presently states on its
28 website that “[d]uring this past summer, we requested US Club Soccer meet with our Board of

1 Directors to review everything in Norcal Premier Soccer. We wanted their advice on how to structure
 2 or restructure the NorCal Premier Soccer organization to ensure it can properly administer and
 3 provide all programs – at the highest level – into the future. This past November, we met with US
 4 Club President Bill Sage and Ken Chartier and received very valuable feedback.” The club continues
 5 that “[w]e have negotiated with US Club Soccer to receive portion of the registration fees back to
 6 Norcal Premier Soccer to be invested in Coaches Education, Player Development or other areas. The
 7 US Club Soccer Board of Directors will consider this proposal at their January Meetings. We believe
 8 there is considerable support for this proposal.”

9 **6. California Youth Soccer Association, Inc. a/k/a Cal North**

10 91. California Youth Soccer Association, Inc. a/k/a Cal North (“CYSA” or “Cal North”)
 11 is an entity organized under the laws of California and headquartered in this District with its
 12 principal place of business located at 1040 Serpentine Lane, Suite 201, Pleasanton, California.
 13 CYSA states in its federal tax filings that its mission is “to develop, promote, and administer the
 14 game of soccer among youth within N[orthern] California.”

15 92. CYSA is subject to specific and general personal jurisdiction in this District.

16 93. CYSA is headquartered in and serves Northern California. It states on its website that
 17 “[s]ince its first year of inception in 1969, with membership numbers just topping 100,000, CYSA
 18 has grown to largest state youth soccer organization in the United States, counting more than 188,00
 19 members ages 5-19.” CYSA emphasizes numerous Defendants’ control over it, stating that “CYSA
 20 is a member of a much larger soccer community, and therefore its players are members of this world
 21 community.” CYSA continues that “[b]oys and girls register to play with one of the more than 300
 22 clubs or leagues formed by CYSA” in Northern California. CYSA further states that “[c]ach of the
 23 nine districts are CYSA and therefor members of US Youth Soccer and US Soccer. US Soccer, along
 24 with over 197 other national soccer organizations, are members of FIFA, the Federation
 25 Internationale de Football Association. FIFA serves as the international governing body for soccer
 26 and US Soccer has been a member since 1913.” CYSA continues that “[t]ogether, local, national and
 27 international organizations form a family of support for the young soccer players of CYSA” in
 28 Northern California.

IV. FACTUAL BACKGROUND

C. A Primer on Concussions

1. Introduction.

94. The word concussion derives from the Latin *concutere* for “to shake violently.” Concussions are just that – a shaking of the brain inside the skull that changes the alertness of the injured person. That change can be relatively mild (“She was slightly dazed.”) or profound (“She was unconscious.”). Both situations fall within the definition of concussion. Concussions are often classified as a form of mild traumatic brain injury.

95. According to the Centers for Disease Control and Prevention, almost four million sports-and recreation-related concussions are recognized every year, with many times that number occurring but going unrecognized.^{33,34} For young people ages 15 to 24 years, sports are the second leading cause of traumatic brain injury, only behind motor vehicle crashes.² According to research by the NEW YORK TIMES, at least 50 youth football players (high school or younger) from 20 different states have died or sustained serious head injuries on the field since 1997.³⁵ One study estimates that the likelihood of an athlete in a contact sport experiencing a recognized concussion is as high as 20 percent each season.³⁶

2. Occurrence.

96. Concussions happen to all types of athletes – young and old, boys and girls, and in every conceivable sport. Concussions in sports occur when an athlete is slammed and makes sudden and forceful contact. That contact can be with the ground, court, or pool deck. It also can be with a

³³ <http://www.cdc.gov> (homepage on the internet) Concussion in Sports. Centers for Disease Control and Prevention. Atlanta GA; Concussion in Sports 2013 (updated July 22, 2013). Available from <http://www.cdc.gov/concussion/sports/> (accessed February 28, 2014).

³⁴ Langlois, JA, W Rutland-Brown, MMWald. The epidemiology and impact of traumatic brain injury; a brief overview. J Head Trauma Rehabil. 2006;21:375-378.

³⁵ Schwarz, A, Silence on Concussions Raises Risks of Injury. NEW YORK TIMES, September 15, 2007.

³⁶ Gerberich, SG, JD Priest, JR Boen, et al. Concussion incidences and severity in secondary school varsity football players. Am J Public Health; 1983; 73:1370-1375.

1 batted ball, a thrown ball, a kicked ball, a goalpost (football), the boards (hockey), the scorer's table
2 (basketball), and of course another player.

3 97. Concussions can and frequently do occur without any contact with the head. Rather,
4 the player's body receives a jolt that causes his shoulders and head to change speed or direction
5 violently. This motion results in a "whiplash effect." Inside the skull, the brain shifts in the
6 cerebrospinal fluid and bangs against the inside of the skull. Even falling from five or six feet and
7 landing upright, if unexpected and therefore jarring, can send a shock through the spine and shake the
8 head with a force that may cause a concussion. Concussions that are the most damaging to the brain tend to
9 be the ones that involve a direct blow to the head, however.

10 98. With a blow to the front of the head, the brain pushes forward until it crashes into the
11 skull, reverses, and bumps against the back of the skull. This action produces an initial *coup*, then a
12 *contrecoup* injury.

13 **3. Two Forces.**

14 99. Concussions are caused by two types of forces in the form of accelerations, linear and
15 rotational (fig. 6-1). *Linear acceleration* is akin to the straight-on force of a car smashing into a tree.
16 At the moment of impact, the driver's head snaps violently. The collision causes direct brain injury,
17 of course. That damage is worse than it would otherwise be because the inside of the skull is rough,
18 not smooth. Contact between the brain tissue and bony surface can be irritating, sometimes bruising
19 or even tearing brain tissue.

20 100. The second type of force is *rotational acceleration*. Think of a football player running
21 from sideline to sideline and a head-hunting defensive player appearing out of nowhere to make a
22 crunching tackle from the side. The force of the collision violently whips the ball carrier's head to
23 one side. If it's jolting enough, the brain comes into contact with the skull. The cerebrospinal fluid in
24 which the brain floats protects the brain and dampens the impact. However, if the force is large
25 enough, an injury occurs. Driven into the skull by rotational accelerations, the brain can stretch and
26 shear. Blood vessels and brain tissue exposed to this trauma may tear.

27 101. The effects of rotational accelerations can be much worse than those from linear
28 accelerations. Concern about this type of force caused the NFL to outlaw blind-side or "defenseless

1 player” helmet-to-helmet hits. On virtually every hit to the head, both the linear and rotational
2 accelerations are present. Among researchers and other experts, it’s believed that rotational forces are
3 more injurious.³⁷

4 **4. Subconcussive Hits.**

5 102. Subconcussive hits, or impacts that do not produce any clinical concussion symptoms,
6 may also adversely affect cerebral function. Evidence that subconcussive hits may adversely affect
7 cerebral function has been reflected in documented changes in cerebral function (*i.e.*, visual working
8 memory declines), and altered dorsolateral prefrontal cortex activation as assessed by functional
9 magnetic resonance imaging in high school football athletes in the absence of clinical signs of
10 concussion. In lay terms, one study on high school football players found that players who received
11 normal football brain trauma and did not report any concussion symptoms still had functional MRI
12 changes that mimicked concussed players.

13 103. Similarly, in a study of college football players released in 2013, researchers found
14 that the more hits to the head a player absorbed, the higher the blood levels of a particular brain
15 protein, S100B, that is known to leak into the bloodstream after a head injury. Even though none of
16 the football players in the study suffered a concussion during the season, four of them showed signs
17 of an autoimmune response, the presence of S100B antibodies in the players’ blood. The players
18 with the highest number of hits also showed abnormal diffusion tensor imaging findings on MRI DTI
19 studies.

20 104. Some studies have suggested that concussions or a combination of concussions and
21 sub-concussive head impacts may lead to conditions such as chronic traumatic encephalopathy, mild
22 cognitive impairment, and/or depression.

23 **5. Pathological Changes.**

24 105. Pathological changes to the brain’s structure – tears and other injuries – are difficult to
25 see on routine imaging. They are often invisible on head CT scans and routine magnetic resonance
26 imaging (MRI), the imaging tests upon which physicians most often rely. For that reason,

27 ³⁷ Cantu, RC. Biomechanics of head injury. In: Cantu, RC ed. Neurologic Athletic Head and
28 Spine Injuries. W. B. Saunders Co, Philadelphia PA.

1 misconceptions exist about the damage that occurs to the brain from a concussion. Through the
2 years, even medical professionals have questioned whether or not the structure of the brain was
3 different after a concussion than before.

4 106. At the Center for the Study of Traumatic Encephalopathy (CSTE) at Boston
5 University, the brains of more than two hundred deceased professional and amateur athletes have
6 been studied. Several of these athletes died within days of a concussion. Several of their deaths were
7 suicides. These brains were examined by Dr. Ann McKee, a world-renowned neuropathologist.

8 107. Her findings revealed that the brains had multiple microscopic changes such as
9 widespread diffuse axonal swelling and other abnormalities that would have been missed if they had
10 been tested by conventional imaging when they were living. Some of the changes were limited to
11 one region of the brain. In other cases, the pathology was wide-spread over several areas from the
12 cortex and brain stem down to the spinal cord. All the injuries were microscopic but real.

13 6. Metabolic Changes.

14 108. Concussions also trigger a complicated chain of chemical and metabolic reactions,
15 which are known as the *neurometabolic cascade* of concussion (fig. 6-2). These biochemical
16 processes confuse the brain, throwing off its ability to regulate, to transmit signals, and to send
17 messages that control how we think and what we remember.

18 109. From being pushed and pulled violently, the brain goes into an overactive state
19 triggering a massive release of chemicals called *neurotransmitters*. These are the chemicals needed
20 for one neuron to communicate with the next and the next. In this situation, the cells begin
21 communicating in a disorderly way, blasting out impulses to all neurons at the same time so that the
22 system becomes overloaded. At this point the brain loses its ability to regulate certain chemical
23 balances. Potassium ions, which are typically contained within brain cells, flood out. Calcium ions,
24 which are on the outside, rush inside the cells. The brain's chemical batting order is turned upside
25 down, and returning things to normal is a very difficult process. To pump the ions back to the right
26 places, the brain needs energy. But the chemical imbalances resulting from the concussion hinder
27 that process, slowing or preventing the metabolic processes. At a time when the brain needs energy
28 to set itself straight, its ability to make energy is greatly impaired.

110. David Hovda, a well-regarded research scientist at UCLA, has studied these chemical imbalances in laboratory rats. Dr. Hovda's research points out that while cell chemistry in rats is disrupted for a short time after a concussion, it takes longer to return to normal.³⁸ That reversal may occur over weeks, even months. Assuming that our brains function exactly as the brains of rats is quite a leap – and likely inaccurate. Still, it is worth thinking about these findings and what they reveal about concussed athletes.

7. Symptoms.

111. All concussions are accompanied by symptoms which fall into four major categories:

Somatic:	Headaches, nausea, vomiting, balance and/or visual problems, dizzy spells and issues such as sensitivity to light and noise.
Emotional:	Sadness to the point of depression (even suicide), nervousness, and irritability.
Sleep disturbance:	Sleeping more or less than usual and trouble falling asleep.
Cognitive:	Difficulty concentrating, troubles with memory, feeling mentally slow or as if in a fog that will not lift.

112. Symptoms are clues. They reveal many things – the severity of the injury and the pace of recovery, for example. The number and combination of symptoms also can pinpoint areas of the brain affected by a concussion. Those cases in which the symptoms are focal, *i.e.*, the insult is to one brain area, tend to have fewer symptoms of shorter duration. When trauma is diffuse, *i.e.*, spread across several brain regions, the patient has more symptoms that persist longer.

8. Why Youth Soccer Players Are Vulnerable.

113. Considerable research supports the proposition that a child's brain takes longer to recover from concussion or the accumulation of subconcussive hits than an adult's brain. Most of these studies deal with the high school athletes, limiting the conclusions we can draw about younger kids. Yet what is known points to children being at risk for significant post-traumatic issues.

³⁸ Giza CC, Hovda DA. The neurometabolic cascade of concussion. J Athl Train 2001;36:228-235.

1 114. Not surprisingly, the comparison of the two major age groups centers on key
2 developmental differences between adults and children. Several of these differences need
3 emphasizing, all bearing directly on the brain's response to trauma.

4 115. The first aspect concerns *myelin*, the insulating cover of axons that make up the fiber
5 tracts in the brain. Think of a copper wire inside the wall of a house and of the plastic rubber coating
6 around the wire. The coating insulates, protects, and strengthens that wire. The fiber tracts in adult
7 brains have a coating of myelin that acts in the same way, protecting the fibers from injury or insult.
8 If sufficiently severe, brain trauma still can occur, of course, but myelination helps protect from
9 minimal trauma. Children's brains have less myelin, so the neuronal pathways are more easily
10 damaged.

11 116. A second consideration is that of *relative head size*. A child's brain and head are
12 disproportionately large compared to the rest of the body, especially through the first five to eight
13 years of life. This anatomical relationship continues through about the age of 14, by which time a
14 child's skull has grown to be about 90 percent as large as an adult-size one. While this fact seems
15 trivial, it is important to a discussion of concussions and concussion risk. The disproportionately
16 larger head size and weight, coupled with a child's weaker neck, mean that the child can't brace for a
17 hit the way that an adult does. Rotational forces are greater for a child, proportional to the severity of
18 the hit. The hit itself may not generate the same force because of the speed of the collision and the
19 weights of the (junior) players involved, but what is transferred to the head may be as great or
20 greater. It is all about neck strength.

21 117. A third consideration is the effect of *cumulative trauma* through a person's life. Total
22 brain trauma is the worry regarding child athletes. If one starts accumulating injuries early in life,
23 chances are that there will be more through one's life experience. No one knows precisely what the
24 effects of that long-term repetitive trauma might be. No head trauma is good head trauma. If
25 knocking around the brain can be avoided, then avoid it.

26 118. A fourth consideration is heading is less risky when kids use their head and neck
27 correctly. The reality is that few do. Many lack the physical maturity to head a soccer ball properly
28 and safely. Their bodies simply have not achieved the maturity and strength.

1 **9. On the Sidelines.**

2 119. On the sidelines, the job of the physician or athletic trainer is to decide whether or not
3 a player can continue in the game. The coach shares that responsibility, but is often saddled with
4 other responsibilities that make it difficult for the coach to make a suitable evaluation. If he or she
5 has any concerns about a particular player, the athlete should be pulled from the game. For the
6 experienced doctor, the evaluation is a matter of looking into the eyes of the player and asking a
7 series of questions. In this situation, the examiner is looking for clues that the individual knows
8 what's going on around them; inappropriate answers to simple questions raise concerns.

9 120. Questions that may be used are the following: What was the play you were injured
10 on? What was the color of the jerseys of the opposing team? (This question is asked without letting
11 the player turn around to look.) What quarter is it? What's the score? These questions reveal whether
12 or not the athlete is alert to what was happening at the time of the injury. Of course, there is always
13 the simplest question of all: Do you remember what happened? Followed by, tell me what you recall.

14 121. If they pass this initial assessment, the examiner moves on to other cognitive tests.
15 One is to give them six digits which they are asked to repeat, then to repeat them backwards. A
16 simple balance test: can the player stand firm with their feet together, in heel-to-toe tandem position,
17 and on one foot, eyes open and then closed; with hands on hips, eyes open and then closed?

18 122. The age of the athlete is important to take into account in performing this assessment.
19 While not a big difference exists in evaluating an adult and a young athlete, say down to nine or ten
20 years old, this is not the case with very young children. More explanation is necessary and more care
21 with language is needed with younger children. Both the examiner and child being examined must be
22 clear about the meaning of the words. For example, a young child probably won't know about being
23 "dinged" and would be confused by a term such as "feeling in a fog" since both terms are slang
24 terms used for head trauma. Some will know "dazed" and some won't. The key is to communicate
25 on a level that is understood by the athlete, whatever the age.
26
27
28

10. Incidence of Concussion in Soccer and the Higher Incidence of Concussions in Females.

123. The incidence of concussion in soccer has been studied by at least 13 investigators. Roughly, the incidence of concussions in men is 1.08 concussions per 1,000 athletic exposures. Men are 13 times more likely to receive a concussion in a game versus a practice. The incidence rate in female soccer players is 1.42 per 1,000 athletic exposures.³⁹

124. According to a study by RIO, a high school injury surveillance system, over the past five school years girls' soccer has accounted for the third-highest rate of concussions of the popular high school sports.

125. In 2007, a research project led by Dawn Comstock of Ohio State reported this data:

In high school soccer, the girls' concussion rate was 68 percent higher than the rate for boys.

In high school basketball, the concussion rate for girls was three times higher than for boys.

126. The 2007 study also found that recovery time for girls was longer than for boys.

127. In 2011, Comstock published a second research study with results that confirmed what the first had shown. In high school soccer, the concussion rate for girls (0.35 per 1,000 participations by an athlete in a practice or game) was double the rate for boys (.017). In basketball the concussion rate for girls was nearly two times higher than for boys.

128. The particularly high concussion incidence rate in girls' soccer can be partially explained by the fact that girls are more susceptible to concussions across all sports played by both genders, despite rules in lacrosse and hockey aimed at diminishing contact, according to multiple studies.

129. Four studies have employed neuropsychological screening batteries to assess soccer players' cognitive functioning and two have found that soccer players exhibit significant cognitive deficits following concussion.^{40,41} Using the ImPACT computer-based testing batter, Colvin et al.⁴²

³⁹ Maher et al., Brain Injury, Concussions and Heading in Soccer (2014).

⁴⁰ Ellemberg D. Leclerk S, Couture S. Daigle C. Prolonged neuro-psychological impairments following a first concussion in female university soccer athletes. Clinical Journal of Sport Medicine: Official Journal of the Canadian Academy of Sport Medicine 2007; 17:369-374.

1 found concussed soccer players ~9 days post-injury displayed significant impairments in memory,
 2 reaction time and visual-processing speed, and impairments were more pronounced for females.
 3 Additionally, athletes who had previously experienced a concussion had significantly worse test
 4 scores for memory and visual-processing speed than those with a first concussion. It is important to
 5 note that, in both studies, female athletes reported significantly more concussion symptoms than
 6 male soccer players.

7 130. There are at least 11 studies that have examined the long-term impacts of heading.
 8 Maher et al. found amateur soccer players to be significantly impaired in attention and memory.⁴³

9 131. The long-term cognitive effects of repetitive, sub-concussive contacts as a result of
 10 heading was demonstrated by Downs and Abwender.⁴⁴ In this study, cognitive testing performance
 11 of current collegiate, professional, older professional or retired soccer players were compared to
 12 healthy controls. The control consisted of current collegiate, professional and master's level
 13 swimmers, as these athletes were considered comparable to soccer players in terms of physical
 14 abilities and training schedule, but without the risk of head injury. Swimmers performed better than
 15 soccer players in tests of conceptual thinking, while it was demonstrated that older or retired soccer
 16 players were significantly impaired ($p<0.05$) in conceptual thinking, reaction time and concentration
 17 compared with all other groups, including the current younger soccer players. Tysvaer and Lochen⁴⁵
 18 examined neuropsychological performance of retired soccer players formerly of the Norwegian
 19 National Team (aged 35-64) and found that they displayed significantly poorer verbal and
 20 performance IQ ($p<0.05$) and were impaired on the Trail Making Test Part A and B ($p<0.01$) as
 21

22 ⁴¹ Colvin AC, Mullen J, Lovell MR, West RV, Collins MW, Groh M. The role of concussion
 23 history and gender in recovery from soccer-related concussion. The American Journal of Sports
 Medicine 2009; 37:1699-1704.

24 ⁴² Colvin AC, Mullen J, Lovell MR, West RV, Collins MW, Groh M. The role of concussion
 25 history and gender in recovery from soccer-related concussion. The American Journal of Sports
 Medicine 2009; 37:1699-1704.

26 ⁴³ Maher et al at 278.

27 ⁴⁴ Downs DS, Abwender D. Neuropsychological impairment in soccer athletes. The Journal of
 28 Sports Medicine and Physical Fitness 2002; 42:103-107.

⁴⁵ Tysvaer A, Lochen E. Soccer injuries to the brain: A neuropsychologic study of former soccer
 players. The American Journal of Sports Medicine 1991; 19:56-60.

1 compared to a control group. In 2005 and 2009 studies, Rutherford et al.^{46,47} found significant
 2 differences between soccer players and controls in divided attention⁴⁸ and that the number of head
 3 injuries sustained interacted significantly with heading frequency to predict scores on alertness,
 4 working memory and language.⁴⁹

5 132. A recent study found that girls who play soccer while in middle school are
 6 particularly vulnerable to concussions. Dr. Melissa Schiff, a professor of epidemiology at the
 7 University of Washington found 59 concussions in an evaluation of 351 players ages 11-14. This rate
 8 of injuries is higher than in either high school or college. Heading the ball accounted for 30% of the
 9 injuries.⁵⁰

10 **D. Consensus Best Practices for the Treatment of Concussion for the Period** 11 **2002-Present**

12 **1. Vienna Protocol.**

13 133. As of 2002, consensus had been reached in the medical and scientific community for
 14 the cornerstones of the management and treatment of concussions.

15 134. The “Summary and Agreement Statement of the First International Conference on
 16 Concussion and Sport, Vienna 2001” (“International Consensus Statement” or “Vienna Protocol”)
 17 was published in early 2002 simultaneously in the *Clinical Journal of Sports Medicine, Physician*
 18 *and Sports Medicine* and *British Journal of Sports Medicine*.⁵¹ The expert group who compiled the

19 ⁴⁶ Rutherford A, Stephens R, Potter D, Fernie G. Neuropsychological impairment as a
 20 consequence of football (soccer) play and football heading: Preliminary analyses and report on
 university footballers. *Journal of Clinical and Experimental Neuropsychology* 2005; 27:299-319.

21 ⁴⁷ Rutherford A, Stephens R, Fernie G, Potter D. Do UK university football club players suffer
 22 neuropsychological impairment as a consequence of their football *(soccer) play? *Journal of Clinical*
and Experimental Neuropsychology 2009; 31:664-681.

23 ⁴⁸ Rutherford A, Stephens R, Potter D, Fernie G. Neuropsychological impairment as a
 24 consequence of football (soccer) play and football heading: Preliminary analyses and report on
 university footballers. *Journal of Clinical and Experimental Neuropsychology* 2005; 27:299-319.

25 ⁴⁹ Rutherford A, Stephens R, Fernie G, Potter D. Do UK university football club players suffer
 neuropsychological impairment as a consequence of their football *(soccer) play? *Journal of Clinical*
and Experimental Neuropsychology 2009; 31:664-681.

26 ⁵⁰ [http://health.usnews.com/health-news/news/articles/2014/01/20/concussions-common-in-](http://health.usnews.com/health-news/news/articles/2014/01/20/concussions-common-in-middle-school-girls-playing-soccer-study)
 27 [middle-school-girls-playing-soccer-study.](http://health.usnews.com/health-news/news/articles/2014/01/20/concussions-common-in-middle-school-girls-playing-soccer-study)

28 ⁵¹ M. Aubry et al., *Summary and Agreement Statement of the First International Conference on*
Concussion in Sport, Vienna 2001, 36 *BRIT. J. SPORTS MED.* 6 (2002) (“Vienna Protocol”).

International Consensus Statement, known as the “Concussion in Sport Group,” was comprised of a panel of world experts and was organized by the International Ice Hockey Federation, the Federation Internationale de Football Association Medical Assessment and Research Center (*i.e.*, FIFA), and the International Olympic Committee Medical Commission (IOC). The International Consensus Statement was intended to be, and accepted as, “a comprehensive systematic approach to concussion to aid the injured athlete and direct management decisions.” It was also intended to “be widely applicable to sport related concussion” and “developed for use by doctors, therapists, health professionals, coaches, and other people involved in the care of injured athletes, whether at the recreational, elite, or professional level.” The Concussion in Sport Group subsequently met in Prague (2004),⁵² Zurich (2008),⁵³ and Zurich (2012), and published updated Consensus Statements. The International Consensus Statement set forth a revised definition of concussion, a standard concussion-management protocol, and discussed the issues of prevention, education, and future directions for the injury.

135. The first International Symposium on Concussion in Sport was held in Vienna, Austria (“Vienna Conference”) in 2001. The goal was to provide recommendations for the improvement of safety and health of athletes who suffer concussive injuries. The result of the conference was the publication of a consensus statement that was “a comprehensive systematic approach to concussion to aid the injured athlete and direct management decisions” (“Vienna Protocol”). The publication was intended to “be widely applicable to sport related concussion” and was “developed for use by doctors, therapists, health professionals, coaches, and other people involved in the care of injured athletes, whether at the recreational, elite, or professional level.”

136. The Vienna Protocol recommended specific return-to-play guidelines. The Vienna Protocol stated:

When a player shows ANY symptoms or signs of a concussion:

⁵² P. McCrory et al., *Summary and Agreement Statement of the 2nd International Conference in Concussion in Sport, Prague 2004*, 39 BRIT. J. SPORTS MED. 196 (2005) (“Prague Protocol”).

⁵³ P. McCrory et al., *Consensus Statement on Concussion in Sport: The 3rd International Conference on Concussion in Sport held in Zurich*, 43 BRIT. J. SPORTS MED., i76, i78 (2009) (“Zurich Protocol”).

(1) The player should not be allowed to return to play in the current game or practice.

(2) The player should not be left alone; and regular monitoring for deterioration is essential.

(3) The player should be medically evaluated after the injury.

Return to play must follow a medically supervised stepwise process.

A player should never return to play while symptomatic. 'When in doubt, sit them out!'

137. The Vienna Protocol also recommended a return-to-play stepwise process as follows:

It was the consensus of the CISG that a structured and supervised concussion rehabilitation protocol is conducive to optimal injury recovery and safe and successful return to play. The rehabilitation principles were common to all identified programmes and are outlined below. Important principles state that the athlete be completely asymptomatic and have normal neurological and cognitive evaluations before the start of the rehabilitation programme. Therefore, the more prolonged the symptom duration, the longer the athlete will have sat out. The athlete will then proceed stepwise with gradual incremental increases in exercise duration and intensity, and pause or backtrack with any recurrence of concussive symptoms. It is appreciated that, although each step may take a minimum of one day, depending on the duration of symptoms, proceeding through each step may take longer in individual circumstances.

138. The Vienna Protocol provided that return to play after a concussion follows a stepwise process:

- (1) No activity, complete rest. Once asymptomatic, proceed to level.
- (2) Light aerobic exercise such as walking or stationary cycling.
- (3) Sport specific training – for example, skating in hockey, running in soccer.
- (4) Non-contact training drills.
- (5) Full contact training after medical clearance.
- (6) Game play.

With this stepwise progression, the athlete should continue to proceed to the next level if asymptomatic at the current level. If any symptoms

1 occur after concussion, the patient should drop back to the previous
2 asymptomatic level and try to progress again after 24 hours.

3 139. In regards to sideline evaluation, the Vienna Protocol noted that “sideline evaluation
4 includes clinical evaluation of signs and symptoms, ideally using a standardized scale of post-
5 concussion symptoms for comparison purposes, and acute injury testing as described below under
6 neuropsychological testing.” The Vienna Protocol recommended tests such as the Maddock’s
7 questions and the Standardized Assessment of Concussion (SAC) as effective in concussion
8 diagnosis and also stated:

9 Sideline evaluation including neurological assessment and mental
10 status testing is an essential component in the protocol. These
11 evaluations are ideally developed in language translations for
12 international sporting groups ... In the acute assessment of concussive
13 injury – that is, concussion diagnosis – brief neuropsychological test
14 batteries that assess attention and memory function have been shown to
15 be practical and effective. Such tests include the Maddock’s questions
16 and the Standardised Assessment of Concussion (SAC). It is worth
17 noting that standard orientation questions – for example, time, place,
18 person – have been shown to be unreliable in the sporting situation
19 compared with memory assessment.

20 It is recognised, however, that abbreviated testing paradigms are
21 designed for rapid evaluation of concussion on the sidelines and are
22 not meant to replace comprehensive neuropsychological testing, which
23 is sensitive enough to detect subtle deficits that may exist beyond the
24 acute episode.

25 140. In regards to baseline testing and neuropsychological testing, the Vienna Protocol
26 provided that “[o]verriding principles common to all neuropsychological test batteries is the need for
27 and benefit of baseline pre-injury testing and serial follow up.” It noted that the application of
28 neuropsychological testing “has shown to be of value and continues to contribute significant
information in concussion evaluation ... It has been shown that cognitive recovery may precede or
follow resolution of clinical symptoms, suggesting that the assessment of cognitive function should
be an important component in any return to play protocol.” Further, “the consensus of the CISG was
that neuropsychological testing is one of the cornerstones of concussion evaluation and contributes
significantly to both understanding of the injury and management of the individual. Organised sport

1 federations have access to and should attempt to employ such testing as appropriate. To maximise
 2 the clinical utility of such neuropsychological assessment, baseline testing is recommended.”

3 141. Finally, the Vienna Protocol acknowledged education of athletes, colleagues, those
 4 working with athletes and the general public as a “mainstay of progress in this field.” The Vienna
 5 Protocol also recommended the “consideration of rule changes” and noted that “rule enforcement is a
 6 critical aspect of such approaches and referees play an important role.”

7 **2. 2004 National Athletic Trainers’ Association Position Statement: Management of**
 8 **Sport-Related Concussion.**

9 142. A second consensus document on concussion management was issued in 2004 when
 10 the National Athletic Trainers Association (“NATA”) published a position statement regarding
 11 concussion management.⁵⁴ NATA provided extensive recommendations including that “decisions
 12 about an athlete’s return to practice should never be based solely on the use of any one test.” It also
 13 recommended a “cautious clinical judgment” which “takes into account all evaluation options.”

14 143. Specifically, the NATA Position Statement stated:

15 Return to participation after severe or repetitive concussive injury
 16 should be considered only if the athlete is completely symptom free
 17 and has a normal neurologic examination, normal neuropsychological
 18 and postural-stability examinations, and, if obtained, normal
 19 neuroimaging studies (i.e., MRI with gradient echo). It may not be
 20 practical or even possible to use all these assessments in all athletes or
 21 young children, but a cautious clinical judgment should take into
 22 account all evaluation options. Each injured athlete should be
 23 considered individually, with consideration for factors including age,
 24 level of participation, nature of the sport (high risk versus low risk),
 25 and concussion history. Standardized neuropsychological testing,
 26 which typically assesses orientation, immediate and delayed memory
 27 recall, and concentration may assist the ATC and physician in
 28 determining when to disqualify an athlete from further participation.
 Balance testing may provide additional information to assist the
 clinician in the decision-making process of whether to disqualify an
 individual after a concussion. When to disqualify the athlete is one of
 the most important decisions facing the ATC and team physician when
 dealing with an athlete suffering from a concussion. This includes not

⁵⁴ K.M. Guskiewicz et al., *National Athletic Trainers’ Association Position Statement: Management of Sport-Related Concussion*, 39 J. ATHLETIC TRAINING 280 (2004) (“NATA 2004 Statement”).

only when to disqualify for a single practice or event but also when to disqualify for the season or for a career.

144. It further stated:

The decision to disqualify an individual from further participation on the day of the concussive episode is based on the sideline evaluation, the symptoms the athlete is experiencing, the severity of the apparent symptoms, and the patient's past history. The literature is clear: any episode involving LOC or persistent symptoms related to concussion (headache, dizziness, amnesia, and so on), regardless of how mild and transient, warrants disqualification for the remainder of that day's activities.

145. The NATA Position Statement similarly recommended baseline testing; the use of objective concussion assessment tools; a combination of screening tools for the sideline; and implementation of a neuropsychological testing program with evaluations by persons appropriately trained in the test administration and scoring (ideally by a neuropsychologist).

3. 2006 American College of Sports Medicine Concussion Consensus Statement.

146. The American College of Sports Medicine's "Concussion (Mild Traumatic Brain Injury) and the Team Physician: A Consensus Statement" provided that a detailed/systematic plan for the team physician to follow in the evaluation of an individual for concussion on the sideline should be developed; noted that post injury neuropsychological data is more useful if compared to a baseline; a team physician should perform serial neurological assessments as an essential function; that it is desirable that the education of the athlete and others about concussion; and that helmets do not prevent, and may actually increase, the incidence of concussion.⁵⁵

147. Regarding same-day RTP, the consensus statement provided:

[i]t is *essential* the team physician understand:

- There is agreement that athletes with significant, persistent or worsening signs and symptoms (e.g., abnormal neurological examination, ongoing RGA or PTA, prolonged LOC) should not RTP.
- For other athletes with concussion, significant controversy exists for a same-day RTP decision and no conclusive

⁵⁵ American College of Sports Medicine, *Concussion (Mild Traumatic Brain Injury) and the Team Physician: A Consensus Statement*, MED. SCI. SPORTS & EXERCISE, 395, 396 (2006).

evidence-based data are available. Areas of controversy include:

- Returning an athlete with any symptoms to play.
- Returning an athlete with fully resolved symptoms to play.
- Certain symptoms, even if resolved, are contraindications to same-day RTP (e.g., any LOC, PTA, and RGA).
- The duration and severity of symptoms are the determining factors of RTP.
- It is the safest course of action to hold an athlete out.

148. Regarding post-game-day RTP, the consensus statement provided:

[i]t is *essential* the team physician understand:

- Determine the athlete is asymptomatic at rest before resuming any exertional activity.
- Amnesia may be permanent.
- Utilize progressive aerobic and resistance exercise challenge tests before full RTP.
- Consider factors which may affect RTP, including:
 - Severity of the current injury
 - Previous concussions (number, severity, proximity)
 - Significant injury in response to a minor blow
 - Age (developing brain may react differently to trauma than mature brain)
 - Sport
 - Learning disabilities
- Understand contraindications for return to sport (e.g., abnormal neurological examination, signs or symptoms with exertion, significant abnormalities on cognitive testing or imaging studies).
- Controversy exists for postgame RTP decisions.

1 It is *desirable* the team physician:

- 2 • Coordinate a team to implement progressive aerobic and
- 3 resistance exercise challenge tests before full RTP.
- 4 • Recognize challenging cognitive effort may exacerbate
- 5 symptoms of concussion and retard recovery.
- 6 • Discuss status of athlete with parents, caregivers, teachers,
- 7 certified athletic trainers and coaching staff within disclosure
- 8 regulations.
- Consider neuropsychological testing.

9 (Emphasis in original.)

10 **4. NFL 2007 Return to Play.**

11 149. The NFL is now known to have hidden for at least a decade its knowledge of
12 concussion injuries so it is hardly a paradigm of concussion management.

13 150. The first return-to-play/concussion standards in the NFL were adopted in 2007. While
14 the adoption by the NFL of the policy was late and incomplete, it reflected an important change that
15 should have caused the Defendants to adopt rules also.

16 151. The NFL policy stated that a player should not be allowed to return in the same game
17 if a player lost consciousness and also required mandatory baseline testing.⁵⁶

18 152. The 2007 policy placed an emphasis on taking a conservative approach to managing
19 concussions including “giving full consideration to a player’s medical history, including his history
20 of concussions and recovery from any previous concussions, and taking the necessary time to
21 conduct a thorough neurological examination, including mental status at rest and post-exertion
22 before making a decision on returning a player to practice or play.”

23 153. The 2007 policy also mandated baseline testing:⁵⁷

25 ⁵⁶ Press Release, *NFL Outlines Standards for Concussion Management* (May 22, 2007),
26 available at [http://www.nflevolution.com/wordpress/wp-content/uploads/](http://www.nflevolution.com/wordpress/wp-content/uploads/2012/08/concussion_standards-508.pdf)
2012/08/concussion_standards-508.pdf; NCAA10044661-62.

27 ⁵⁷ Press Release, *NFL Outlines Standards for Concussion Management* (May 22, 2007),
28 available at [http://www.nflevolution.com/wordpress/wp-](http://www.nflevolution.com/wordpress/wp-content/uploads/2012/08/concussion_standards-508.pdf)
content/uploads/2012/08/concussion_standards-508.pdf.

Neuropsychological baseline testing will be required for all NFL players beginning this season, using a standardized test to establish an individual functional baseline. Neuropsychological testing is one tool a physician can use to assist in the management of MTBI. It cannot be used by itself to make clinical decisions. For players removed from games due to concussions, repeat testing will be done during the season to track recovery and to help decide when they can return to play. These players also will be re-tested against their baseline performance the following season at training camp.

154. Finally, the NFL took some steps to educate players in a 2007 “concussion pamphlet”.⁵⁸

(1) The player should be completely asymptomatic and have normal neurological test results, including mental status testing at rest and after physical exertion before returning to play; (2) Symptoms to be taken into account include confusion, problems with immediate recall, disorientation to time, place and person, anterograde and retrograde amnesia, fatigue, and blurred vision; (3) if an NFL player sustains a loss of consciousness, as determined by the team medical staff, he should not return to the same game or practice; (4) NFL team physicians and athletic trainers will continue to exercise their medical judgment and expertise in treating concussions, including considering any history of concussion in a player.

5. The 2008 Zurich Protocol.

155. The 3rd International Conference on Concussion in Sport was held in Zurich in November 2008, resulting in an update of the Vienna and Prague Protocols (“Zurich Protocol”).⁵⁹ Once again, the Zurich Protocol reaffirmed the need for a graduated stepwise return-to-play process after a concussion with a 24-hour wait period between each step. The Zurich Protocol mirrors the Prague Protocol in many respects. However, the Zurich Protocol abandoned the simple versus complex terminology developed in Prague and also identified “concussion modifiers” which may affect the recovery and outcome of return-to-play progress. In addition, the Zurich Protocol more specifically enumerated a process for sideline evaluation and developed another standardized concussion assessment tool (SCAT2) for use in concussion evaluation.

⁵⁸ See Press Release, *NFL Outlines For Players Steps Taken to Address Concussions* (Aug. 14, 2007), available at <http://www.nfl.com/news/story/09000d5d8017cc67/article/nfl-outlines-for-players-steps-taken-to-address-concussions>.

⁵⁹ Zurich Protocol, at i78.

156. In regards to return to play, the Zurich Protocol noted:

The cornerstone of concussion management is physical and cognitive rest until symptoms resolve and then a graded programme of exertion prior to medical clearance and return to play. The recovery and outcome of this injury may be modified by a number of factors that may require more sophisticated management strategies. These are outlined in the section on modifiers below. As described above, the majority of injuries will recover spontaneously over several days. In these situations, it is expected that an athlete will proceed progressively through a stepwise return to play strategy. During this period of recovery while symptomatic, following an injury, it is important to emphasise to the athlete that physical and cognitive rest is required. Activities that require concentration and attention (eg, scholastic work, videogames, text messaging, etc) may exacerbate symptoms and possibly delay recovery. In such cases, apart from limiting relevant physical and cognitive activities (and other risk-taking opportunities for re-injury) while symptomatic, no further intervention is required during the period of recovery and the athlete typically resumes sport without further problem.

157. The Protocol further stated:

Return to play protocol following a concussion follows a stepwise process ... With this stepwise progression, the athlete should continue to proceed to the next level if asymptomatic at the current level. Generally each step should take 24 hours so that an athlete would take approximately one week to proceed through the full rehabilitation protocol once they are asymptomatic at rest and with provocative exercise. If any postconcussion symptoms occur while in the stepwise programme, the patient should drop back to the previous asymptomatic level and try to progress again after a further 24-hour period of rest has passed."

158. The Protocol included the following chart:

Graduated Return-to-Play Protocol:

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
1. No activity	Complete physical and cognitive rest	Recovery
2. Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum predicted heart rate No resistance training	Increase heart rate
3. Sport-specific exercise	Skating drills in ice hockey, running drills in soccer. No head impact activities	Add movement
4. Non-contact training drills	Progression to more complex training drills, eg passing drills in football and ice hockey May start progressive resistance training)	Exercise, coordination, and cognitive load
5. Full contact practice	Following medical clearance participate in normal training activities	Restore confidence and assess functional skills by coaching staff
6. Return to play	Normal game play	

159. The Zurich Protocol provided: “An important consideration in RTP is that concussed athletes should not only be symptom-free but also should not be taking any pharmacological agents/medications that may mask or modify the symptoms of concussion.”

160. In regards to “Same day RTP,” the Protocol stated:

With adult athletes, in some settings, where there are team physicians experienced in concussion management and sufficient resources (eg, access to neuropsychologists, consultants, neuroimaging, etc) as well as access to immediate (ie, sideline) neurocognitive assessment, return to play management may be more rapid. The RTP strategy must still follow the same basic management principles namely full clinical and cognitive recovery before consideration of return to play. This approach is supported by published guidelines, such as the American Academy of Neurology, US Team Physician Consensus Statement, and US National Athletic Trainers Association Position Statement. This issue was extensively discussed by the consensus panelists and it was acknowledged that there is evidence that some professional American football players are able to RTP more quickly, with even same day RTP supported by National Football League studies without a risk of recurrence or sequelae. *There are data however, demonstrating that at the collegiate and high school level, athletes allowed to RTP on the same day may demonstrate NP deficits post-injury that may not be evident on the sidelines and are more likely to have delayed onset of symptoms.* It should be emphasised however, that the young (<18) elite athlete should be treated more conservatively even though the resources may be the same as for an older professional athlete.

(Emphasis added.)

161. The Protocol also noted that the panel agreed that a range of “modifying factors” may effect concussion management: “[A] range of ‘modifying’ factors may influence the investigation

and management of concussion and in some cases, may predict the potential for prolonged or persistent symptoms.” *Id.* at i79.

Concussion modifiers:

Factors	Modifier
Symptoms	Number Duration (>10 days) Severity
Signs	Prolonged loss of consciousness (>1 min), amnesia
Sequelae	Concussive convulsions
Temporal	Frequency—repeated concussions over time Timing—injuries close together in time “Recency”—recent concussion or traumatic brain injury
Threshold	Repeated concussions occurring with progressively less impact force or slower recovery after each successive concussion
Age	Child and adolescent (<18 years old)
Co- and pre-morbidities	Migraine, depression or other mental health disorders, attention deficit hyperactivity disorder, learning disabilities, sleep disorders
Medication	Psychoactive drugs, anticoagulants
Behaviour	Dangerous style of play
Sport	High risk activity, contact and collision sport, high sporting level

162. The Zurich Protocol also re-emphasized the importance of neuropsychological and comparative baseline testing but noted that it should not be used as a stand-alone tool or form the sole basis of management decisions but rather as an aid to the clinical decision making process. In addition, the Zurich Protocol noted that “neuropsychologists are in the best position to interpret NP tests by virtue of their background and training ... However, there may be situations where neuropsychologists are not available and other medical professional may perform or interpret NP screening tests.” The Zurich Protocol recommended that all high-risk sports have formal baseline neuropsychological screening, stating “[a]lthough formal baseline NP screening may be beyond the resources of many sports or individuals, it is recommended that in all organised high risk sports consideration be given to having this cognitive evaluation regardless of the age or level of performance.” Finally, the Zurich Protocol noted that: “in the absence of NP and other testing, a more conservative return to play approach may be appropriate.”

163. The Zurich Protocol also expanded upon the sideline evaluation of concussion and formulated the SCAT2. The Zurich Protocol specifically stated:

When a player shows **any** features of a concussion:

- a. The player should be medically evaluated onsite using standard emergency management principles and particular attention should be given to excluding a cervical spine injury.
- b. The appropriate disposition of the player must be determined by the treating healthcare provider in a timely manner. If no healthcare provider is available, the player should be safely removed from practice or play and urgent referral to a physician arranged.
- c. Once the first aid issues are addressed, then an assessment of the concussive injury should be made using the SCAT2 or other similar tool.
- d. The player should not be left alone following the injury and serial monitoring for deterioration is essential over the initial few hours following injury.
- e. A player with diagnosed concussion should not be allowed to return to play on the day of injury. Occasionally in adult athletes, there may be return to play on the same day as the injury

Sideline evaluation of cognitive function is an essential component in the assessment of this injury. Brief neuropsychological test batteries that assess attention and memory function have been shown to be practical and effective. Such tests include the Maddocks questions and the Standardized Assessment of Concussion (SAC). It is worth noting that standard orientation questions (eg, time, place, person) have been shown to be unreliable in the sporting situation when compared with memory assessment. It is recognised, however, that abbreviated testing paradigms are designed for rapid concussion screening on the sidelines and are not meant to replace comprehensive neuropsychological testing which is sensitive to detect subtle deficits that may exist beyond the acute episode; nor should they be used as a stand-alone tool for the ongoing management of sports concussions. It should also be recognised that the appearance of symptoms might be delayed several hours following a concussive episode.

(Internal citations omitted.)

164. The Zurich Protocol again emphasized the necessity of concussion education. “As the ability to treat or reduce the effects of concussive injury after the event is minimal, education of

1 athletes, colleagues and the general public is a mainstay of progress in this field. Athletes, referees,
 2 administrators, parents, coaches and healthcare providers must be educated regarding the detection of
 3 concussion, its clinical features, assessment techniques and principles of safe return to play.”

4 165. Finally, the Zurich Protocol noted that there is no evidence that protective equipment,
 5 including helmets, will prevent concussion. “There is no good clinical evidence that currently
 6 available protective equipment will prevent concussion although mouthguards have a definite role in
 7 preventing dental and orofacial injury. Biomechanical studies have shown a reduction in impact
 8 forces to the brain with the use of head gear and helmets, but these findings have not been translated
 9 to show a reduction in concussion incidence.”

10 **6. In 2009, Even the “NFL Adopts Stricter Statement on Return to Play Following**
 11 **Concussions.”**

12 166. In 2009, the NFL’s medical committee on concussions, in conjunction with team
 13 doctors, outside medical experts, and the NFL Players Association, adopted stricter standards of
 14 return-to-play decisions after concussions.⁶⁰

15 167. The 2009 standards provided that a player who suffers a concussion should not return
 16 to play or practice on the same day if he shows any signs or symptoms of a concussion. The
 17 statement mandates:

18 Once removed for the duration of the practice or game, the player
 19 should not be considered for return-to-football activities until he is
 20 fully asymptomatic, both at rest and after exertion, has a normal
 21 neurological examination, normal neuropsychological testing, and has
 22 been cleared to return both by his team physician(s) and the
 independent neurological consultant. These independent consultants
 have been approved by both the NFL Medical Advisor and the Medical
 Director of the NFL Players Association.

23 A critical element of managing concussions is candid reporting by
 24 players of their symptoms following an injury. Accordingly, players
 25 are to be encouraged to be candid with team medical staffs and fully
 disclose any signs or symptoms that may be associated with a
 concussion.

26 ⁶⁰ See Press Release, *NFL Adopts Stricter Statement on Return-to-Play Following Concussions*
 27 (Dec. 2, 2009), available at [http://www.nflevolution.com/wordpress/wp-content/uploads/2012/08/](http://www.nflevolution.com/wordpress/wp-content/uploads/2012/08/nfl_adopts_stricter_statement_on_return-to-play_following_concussions-508.pdf)
 28 [nfl_adopts_stricter_statement_on_return-to-play_following_concussions-508.pdf](http://www.nflevolution.com/wordpress/wp-content/uploads/2012/08/nfl_adopts_stricter_statement_on_return-to-play_following_concussions-508.pdf); see also
 NCAA10044661-62.

168. The 2009 NFL standards stated that a player who suffers a concussion should not return to play or practice on the same day if any of the following symptoms are identified based on the initial medical evaluation of the player:

- Loss of consciousness;
- Confusion as evidenced by disorientation to person, time or place; inability to respond appropriately to questions; or inability to remember assignments or plays;
- Amnesia as evidenced by a gap in memory for events occurring just prior to the injury inability to learn and retain new information; or a gap in memory for events that occurred after the injury;
- Abnormal neurological examination, such as abnormal pupillary response, persistent dizziness or vertigo, or abnormal balance on sideline testing;
- New and persistent headache, particularly if accompanied by photosensitivity, nausea, vomiting or dizziness; and
- Any other persistent signs or symptoms of concussion.

7. In 2011, the NFL Implemented a Standardized Concussion Assessment Protocol.

169. In 2011, the NFL implemented standardized sideline concussion tests to be administered to injured athletes called the “NFL Sideline Concussion Assessment Protocol” and also a standardized baseline test.

170. The sideline protocol was apparently a result of a survey of team medical staffs and input from the players union and mirrors many aspects of the 2008 Zurich SCAT2 protocol. Notably, the NFL protocol was developed by its Head, Neck and Spine Committee, and specifically the return-to-play subcommittee which is chaired by Dr. Margot Putukian, who also consults to the NCAA.⁶¹

171. First, players must take a baseline test prior to the season. Once a player is injured, players must be evaluated with a standardized test “derived from the Standardized Concussion

⁶¹ *NFL Launches New Guidelines for Assessing Concussions*, USA TODAY (Mar. 30, 2011), available at http://usatoday30.usatoday.com/sports/football/nfl/2011-03-29-concussions-protocol_N.htm.

Assessment Tool 2 (SCAT2) and represents a standardized method of evaluating NFL players for concussion consistent with the reasonable, objective practice of the healthcare profession.” The protocol states that “If ANY significant abnormality is found, a conservative, ‘safety first’ approach should be adopted. An athlete suspected of sustaining a concussion is a ‘No Go’ and does not return to play in the same game or practice.” Moreover, the comparison is being done real-time in the NFL using iPad apps.⁶²

172. The NFL explained: “The hope is that being able to compare the results of a baseline test and post-injury test side by side in real time will speed diagnosis and help doctors and trainers recognize when a player should be removed from a game. The league also plans to have independent neurological consultants on the sideline during each game to assist the team physician in diagnosing and treating players.”⁶³

8. American College of Sports Medicine’s Concussion (Mild Traumatic Brain Injury) and the Team Physician: A Consensus Statement – 2011 Update.

173. The 2011 Update by the American College of Sports Medicine revised recommendations regarding mild traumatic brain injury from the 2006 edition.⁶⁴ The 2011 Update provided:

- No same day return-to play (RTP).
- Neurological examination emphasizing cognitive function and balance.
- Role and limitations of neuropsychological (NP) testing.
- Utility of standardized baseline and post injury assessments.
- Importance of preseason planning.
- Acknowledged importance of cognitive rest.

⁶² Judy Battista, *NFL Will Expand Concussion Efforts During Games*, N.Y. TIMES (Feb. 26, 2013), available at http://www.nytimes.com/2013/02/27/sports/football/nfl-will-use-ipads-to-expand-in-game-concussion-testing.html?ref=judybattista&_r=0.

⁶³ *Id.*

⁶⁴ American College of Sports Medicine, *Concussion (Mild Traumatic Brain Injury) and the Team Physician: A Consensus Statement - 2011 Update*, MED. SCI. SPORTS & EXERCISE 2412, 2415 (2011).

- Acknowledged emerging technologies and their role in concussion research.
- Recognition of long-term complications of concussion.
- Legislation and governing body regulations for concussion.

174. In addition, the 2011 Update provided:

It is *essential* the team physician understand:

- Before resuming exercise, the athlete must be asymptomatic or returned to baseline symptoms at rest and has no symptoms with cognitive effort.
 - Amnesia surrounding the event may be permanent.
- An athlete should no longer be taking medications that may mask or modify concussion symptoms.
- The athlete's clinical neurological examination (cognitive, cranial nerve, and balance testing) have returned to baseline before resuming exercise.
- If performed, NP testing returns to at-least baseline before resuming contact/collision activities.
- Progressive aerobic and resistance exercise challenge tests should be utilized before full RTP
 - This process may take days, weeks, or months.
 - Recurrence of symptoms and/or signs warrants additional rest and monitoring.
- Certain risk factors may affect RTP decision making.
- Additional factors may affect RTP decision making:
 - Risk-taking behaviors
 - Type of sport

It is *desirable* the team physician:

- Coordinate a team to implement sport-specific progressive aerobic and resistance exercise challenge tests before full RTP.

- Facilitate academic accommodations for symptomatic student athletes.
- Discuss status of athlete with parents/guardians, caregivers, certified athletic trainers, coaches, school officials, and others within disclosure regulations.

(Internal citations omitted) (emphasis in original).

175. The ACSM also published a 2012 Update.⁶⁵ Regarding “Establishing a Return to Play Process,” the 2012 Update states:

Establishing a process for returning an athlete to play is the essential first step in deciding when an injured or ill athlete may safely return to practice or competition. This process should include evaluation of the athlete’s health status, participation risk, and extrinsic factors. The final RTP decision is made by the team physician.

It is essential the team physician:

- Understand the RTP process should be established during the off season.
- Coordinate a chain of command regarding decisions to return an injured or ill athlete to practice or competition.
- Evaluate the athlete’s health status.
 - Medical factors including history, symptoms, signs, and additional tests.
 - Psychological factors, including readiness and coping mechanisms.
 - Functional testing to evaluate readiness to RTP.
 - Nature of the illness/injury including mechanism of injury, natural history, and known risks of participating after illness/injury.
- Evaluate the athlete’s participation risk.
 - Demands of the athlete’s sport, including the position and competitive level of play.

⁶⁵ American College of Sports Medicine, *The Team Physician and the Return-to-Play Decision: A Consensus Statement – 2012 Update*, MED. SCI. SPORTS & EXERCISE 2446, 2447 (2012).

- Role of taping, bracing, or orthoses to protect the athlete.
 - Role of medical interventions that allow an athlete to play (e.g., analgesics/injections, inhalers, and intravenous fluids).
 - RTP may affect other athletes (e.g., bracing, casting, and disease transmission).
 - Understand extrinsic factors that may modify the acceptable level of risk (risk/gain ratio) for the individual athlete (e.g., pressure from parents, team and/or coaches, conflicts of interest and other ethical considerations, fear of litigation, point in athlete's season, or career).
 - Communicate the RTP process to players, families, certified athletic trainers, coaches, administrators, and other health care providers.
 - Confirm a system for medical documentation is in place.
 - Establish protocols within disclosure regulations for the release of information regarding an athlete's ability to return to practice or competition after an injury or illness.
 - Understand certain sports have governing body rules and regulations regarding participation that affect the RTP decision (e.g., no knee brace in rugby and skin infection in wrestling).
 - Understand federal, state, and local regulations and legislation related to returning an injured or ill athlete to practice or competition.
- It is desirable the team physician:
- Work with the athletic care network to educate athletes, parents, and coaches about the RTP process.
 - Prepare a letter of understanding between the team physician and the administration that defines the authority, responsibilities, and RTP decisions."

(Internal citations omitted.)

1 **9. 2013 American Academy of Neurology Update.**

2 176. On March 18, 2013, the American Academy of Neurology (“AAN”) replaced its 1997
3 practice parameter regarding sports concussion with the *Summary of Evidence-Based Guideline*
4 *Update: Evaluation and Management of Concussion in Sports* (“AAN Update”).⁶⁶

5 177. The AAN Update recommended the following diagnostic tools as useful in
6 identifying those with concussion: Post-Concussion Symptom Scale or Graded Symptom Checklist;
7 Standardized Assessment of Concussion; neuropsychological testing; Balance Error Scoring System;
8 Sensory Organization Test; and these diagnostic measures used in combination.⁶⁷ With respect to
9 neuropsychological testing, the AAN stated that such testing:

10 generally require[s] a neuropsychologist for accurate interpretation,
11 although [it] may be administered by a non-neuropsychologist. It is
12 likely that neuropsychological testing of memory performance,
13 reaction time, and speed of cognitive processing, regardless of whether
 administered by paper-and-pencil or computerized method, is useful in
 identifying the presence of concussion.⁶⁸

14 The AAN further stated that the above diagnostic tools may be used to identify athletes with “chronic
15 neurobehavioral impairments.”⁶⁹

16 178. The AAN also provided three sets of recommendations, regarding:
17 (1) preparticipation counseling; (2) the assessment, diagnosis, and management of suspected
18 concussion; and (3) the management of diagnosed concussion (including acute management, RTP,
19 and retirement).⁷⁰

20 179. First, with respect to preparticipation counseling, the AAN recommended that
21 “school-based professionals be educated by experienced LHCPs [licensed healthcare providers]
22
23

24 ⁶⁶ American Academy of Neurology, *Summary of Evidence-Based Guideline Update: Evaluation*
25 *and Management of Concussion in Sports* (2013), available at [http://neurology.org/](http://neurology.org/content/early/2013/03/15WNL.0b013e31828d57dd)
[content/early/2013/03/15WNL.0b013e31828d57dd](http://neurology.org/content/early/2013/03/15WNL.0b013e31828d57dd).

26 ⁶⁷ *Id.* at 3.

27 ⁶⁸ *Id.* (citations omitted).

28 ⁶⁹ *Id.*

⁷⁰ *Id.* at 4.

1 designated by their organization/institution to understand the risks of experiencing a concussion so
2 that they may provide accurate information to parents and athletes.”⁷¹

3 180. Second, with respect to the management of diagnosed concussion, the AAN Update
4 addressed RTP and the risk of recurrent concussion, and provided:

- 5 1. In order to diminish the risk of recurrent injury, individuals
6 supervising athletes should prohibit an athlete with concussion
7 from returning to play/practice (contact-risk activity) until an
8 LHCP has judged that the concussion has resolved.
- 9 2. In order to diminish the risk of recurrent injury, individuals
10 supervising athletes should prohibit an athlete with concussion
11 from returning to play/practice (contact-risk activity) until the
12 athlete is asymptomatic off medication.⁷²

13 181. The AAN also recommended “cognitive restructuring counseling” consisting of
14 “education, reassurance, and reattribution of symptoms,” which has been shown to decrease the
15 proportion of individuals with mTBI who develop chronic postconcussion syndrome.⁷³

16 182. Finally, the AAN stated that LHCPs “should counsel athletes with a history of
17 multiple concussions and subjective persistent neurobehavioral impairment about the risk factors for
18 developing permanent or lasting neurobehavioral or cognitive impairments.”⁷⁴

19 **10. 2013 Zurich II Protocol.**

20 183. The 4th International Conference on Concussion in Sport was held in Zurich in
21 November 2012, resulting in an update of the Vienna, Prague and Zurich Protocols (“Zurich II”).⁷⁵
22 Zurich II provided only modest updates to the prior consensus guidelines.

23 184. With respect to pre-participation concussion management, Zurich II stated:⁷⁶

24 ⁷¹ *Id.*

25 ⁷² *Id.* at 5.

26 ⁷³ *Id.*

27 ⁷⁴ *Id.* at 6.

28 ⁷⁵ P. McCrory et al., *Consensus statement on concussion in sport: the 4th International Conference on Concussion in Sport held in Zurich, November 2012*, 47 BRIT. J. SPORTS MED. 250 (2013), available at <http://bjsm.bmj.com/content/47/5/250.full.pdf+html>. (“Zurich II Protocol”).

⁷⁶ *Id.*

1 Recognising the importance of a concussion history, and appreciating
 2 the fact that many athletes will not recognise all the concussions they
 3 may have suffered in the past, a detailed concussion history is of value.
 4 Such a history may preidentify athletes who fit into a high-risk
 5 category and provides an opportunity for the healthcare provider to
 6 educate the athlete in regard to the significance of concussive injury. A
 7 structured concussion history should include specific questions as to
 8 previous symptoms of a concussion and length of recovery; not just the
 9 perceived number of past concussions. It is also worth noting that
 10 dependence on the recall of concussive injuries by teammates or
 11 coaches has been demonstrated to be unreliable.

8 The clinical history should also include information about all previous
 9 head, face or cervical spine injuries as these may also have clinical
 10 relevance. It is worth emphasising that in the setting of maxillofacial
 11 and cervical spine injuries, coexistent concussive injuries may be
 12 missed unless specifically assessed. Questions pertaining to
 13 disproportionate impact versus symptom severity matching may alert
 14 the clinician to a progressively increasing vulnerability to injury. As
 15 part of the clinical history, it is advised that details regarding protective
 16 equipment employed at the time of injury be sought, both for recent
 17 and remote injuries.

14 There is an additional and often unrecognised benefit of the
 15 preparticipation physical examination insofar as the evaluation allows
 16 for an educative opportunity with the player concerned as well as
 17 consideration of modification of playing behaviour if required.

17 185. Zurich II also emphasized the necessity of concussion education before a concussion
 18 has occurred, stating:⁷⁷

19 As the ability to treat or reduce the effects of concussive injury after
 20 the event is minimal, education of athletes, colleagues and the general
 21 public is a mainstay of progress in this field. Athletes, referees,
 22 administrators, parents, coaches and healthcare providers must be
 23 educated regarding the detection of concussion, its clinical features,
 24 assessment techniques and principles of safe return to play.

23 186. In regards to “Same day RTP” after a concussion, Zurich II again reinforced:⁷⁸

24 It was unanimously agreed that no RTP on the day of concussive injury
 25 should occur. There are data demonstrating that at the collegiate and
 26 high school levels, athletes allowed to RTP on the same day may

27 ⁷⁷ *Id.* at 5.

28 ⁷⁸ *Id.* at 3.

demonstrate NP deficits postinjury that may not be evident on the sidelines and are more likely to have delayed onset of symptoms.

187. With respect to return to play, Zurich II stated: “The cornerstone of concussion management is physical and cognitive rest until symptoms resolve and then a graded programme of exertion prior to medical clearance and return to play.”⁷⁹ Zurich II further stated:⁸⁰

Return to play protocol following a concussion follows a stepwise process ... With this stepwise progression, the athlete should continue to proceed to the next level if asymptomatic at the current level. Generally, each step should take 24 h so that an athlete would take approximately one week to proceed through the full rehabilitation protocol once they are asymptomatic at rest and with provocative exercise. If any postconcussion symptoms occur while in the stepwise programme, then the patient should drop back to the previous asymptomatic level and try to progress again after a further 24 h period of rest has passed.

188. Zurich II included the following chart:⁸¹

Graduated Return-to-Play Protocol:

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
1. No activity	Symptom limited physical and cognitive rest	Recovery
2. Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum permitted heart rate No resistance training	Increase HR
3. Sport-specific exercise	Skating drills in ice hockey, running drills in soccer. No head impact activities	Add movement
4. Non-contact training drills	Progression to more complex training drills, eg, passing drills in football and ice hockey May start progressive resistance training	Exercise, coordination and cognitive load
5. Full-contact practice	Following medical clearance participate in normal training activities	Restore confidence and assess functional skills by coaching staff

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Id.* at 4.

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
6. Return to play	Normal game play	

189. Zurich II explained that a single return-to-play paradigm should be used for all athletes and that formal neuropsychological testing should be used in high risks sports regardless of age or level of competition, explaining:⁸²

All athletes regardless of level of participation should be managed using the same treatment and return to play paradigm. The available resources and expertise in concussion evaluation are of more importance in determining management than a separation between elite and non-elite athlete management. Although formal NP testing may be beyond the resources of many sports of individuals, it is recommended that, in all organised high-risk sports, consideration be given to having this cognitive evaluation, regardless of the age or level of performance.

190. Zurich II also re-emphasized the importance of neuropsychological testing but noted that it should not be used as a stand-alone tool or form the sole basis of management decisions but rather as an aid to the clinical decision making process. In addition, Zurich II recommended that “all athletes should have a clinical neurological assessment (including assessment of their cognitive function) as part of their overall management,” and that NP testing should ideally be performed by trained neuropsychologists who are “in the best position to interpret NP tests by virtue of their background and training....”⁸³ Zurich II recommended that all high-risk sports, regardless of the age or level of performance, have formal baseline neuropsychological screening.⁸⁴

191. Zurich II also suggests that changes in the rules and rule enforcement are critical, especially in soccer:

Consideration of rule changes to reduce the head injury incidence or severity may be appropriate where a clear-cut mechanism is implicated in a particular sport. ***An example of this is in football (soccer) where research studies demonstrated that upper limb to head contact in heading contests accounted for approximately 50% of concussions. As noted earlier, rule changes may also be needed in some sports to allow an effective off-field medical assessment to occur without***

⁸² *Id.* at 5.

⁸³ *Id.* at 7-8.

⁸⁴ *Id.* at 5.

compromising the athlete's welfare, affecting the flow of the game or unduly penalising the player's team. It is important to note that rule enforcement may be a critical aspect of modifying injury risk in these settings, and referees play an important role in this regard.⁸⁵

192. In regards to sideline assessments, Zurich II requires "sufficient time for assessment ... in some sports, this may require rule change to allow an appropriate off-field medical assessment to occur without affecting the flow of the game or unduly penalizing the injured player's team."⁸⁶

193. Finally, Zurich II states specific recommendations regarding child and adolescent athletes:

The evaluation and management recommendations contained herein can be applied to children and adolescents down to the age of 13 years. Below that age, children report concussion symptoms different from adults and would require age-appropriate symptom checklists as a component of assessment. An additional consideration in assessing the child or adolescent athlete with a concussion is that the clinical evaluation by the healthcare professional may need to include both patient and parent input, and possibly teacher and school input when appropriate. A child SCAT3 has been developed to assess concussion (see appendix) for individuals aged 5–12 years.

It was agreed by the panel that no return to sport or activity should occur before the child/adolescent athlete has managed to return to school successfully. In addition, the concept of 'cognitive rest' was highlighted with special reference to a child's need to limit exertion with activities of daily living that may exacerbate symptoms. School attendance and activities may also need to be modified to avoid provocation of symptoms. Children should not be returned to sport until clinically completely symptom-free, which may require a longer time frame than for adults.

Because of the different physiological response and longer recovery after concussion and specific risks (eg, diffuse cerebral swelling) related to head impact during childhood and adolescence, a more conservative RTP approach is recommended. *It is appropriate to extend the amount of time of asymptomatic rest and/or the length of the graded exertion in children and adolescents.* It is not appropriate

⁸⁵ *Id.* at 5-6 (emphasis added).

⁸⁶ *Id.* at 2.

for a child or adolescent athlete with concussion to RTP on the same day as the injury, regardless of the level of athletic performance. Concussion modifiers apply even more to this population than adults and may mandate more cautious RTP advice.⁸⁷

194. The documents set forth above constitute the consensus best practices in the proper assessment and management of concussion for all physician, sub-specialty, and allied health professionals, including athletic trainers and those responsible for the safety, well-being and treatment of athletes.

E. The Power to Protect All Players Starts With FIFA and the Laws of the Game

1. FIFA's Statutes.

195. FIFA's 2013 Financial Report Recognizes FIFA's control over every aspect of soccer at every level:

1.1 FIFA Statutes

The Statutes and the regulations governing their application represent the "constitution" of FIFA and world football. These documents and the key values of authenticity, integrity, performance and unity underpin FIFA's mission: to develop the game, touch the world and build a better future.

According to the Statutes, FIFA's objectives are as follows:

- to improve the game of football constantly and promote it globally in the light of its unifying, educational, cultural and humanitarian values, particularly through youth and development programmes;
- to organize its own international competitions;
- to draw up regulations and provisions and ensure their enforcement;
- to control every type of association football;
- to safeguard the integrity of matches and competitions and prevent abuse of the game.⁸⁸

⁸⁷ *Id.* at 5 (emphasis added).

⁸⁸ http://www.fifa.com/mm/document/affederation/administration/02/30/12/07/fifafr2013en_neutral.pdf, at 50.

196. FIFA states on its website the following:

The Fédération Internationale de Football Association (FIFA) is an association governed by Swiss law founded in 1904 and based in Zurich. It has 209 member associations and its goal, enshrined in its Statutes, is the constant improvement of football. FIFA employs some 310 people from over 35 nations and is composed of a Congress (legislative body), Executive Committee (executive body), General Secretariat (administrative body) and committees (assisting the Executive Committee).⁸⁹

197. FIFA states in its 2013 Financial Report that “[m]embers of FIFA are those associations that are responsible for organising and supervising football in its country. Only one association is recognised in each country.”

198. FIFA states that “[t]he FIFA Statutes and the regulations governing their application represent the ‘constitution’ of FIFA and world football. These documents and the key values of authenticity, integrity, performance and unity underpin FIFA’s mission: to develop the game, touch the world and build a better future.”

199. FIFA in its Statutes defines “Association” as “a football association recognized by FIFA. It is a member of FIFA, unless a different meaning is evident from the context.” FIFA continues that the objectives of FIFA are:

- a) to improve the game of football constantly and promote it globally in the light of its unifying, educational, cultural and humanitarian values, particularly through youth and development programmes;
- b) to organise its own international competitions;
- c) to draw up regulations and provisions and ensure their enforcement;
- d) to control every type of Association Football by taking appropriate steps to prevent infringements of the Statutes, regulations or decisions of FIFA or of the Laws of the Game;
- e) to promote integrity, ethics and fair play with a view to preventing all methods or practices, such as corruption, doping or match manipulation, which might jeopardise the integrity of

⁸⁹ <http://www.fifa.com/aboutfifa/organisation/index.html> (last visited July 28, 2014).

1 matches, competitions, Players, Officials and Members or give
2 rise to abuse of Association Football.⁹⁰

3 200. Each year, FIFA publishes updates and maintains a current version of the manner in
4 which football is played. These rules are followed worldwide, including in either their entirety or in
5 some form in the United States and are called “the Laws of the Game.” The Laws of the Game are
6 equivalent to a religious Bible, Koran or Holy Script. Any modifications to the Laws of the Game by
7 FIFA are either adopted or followed in some manner by all soccer organizations.

8 201. Article 6, titled “Laws of the Game,” states:

- 9 1. Each Member of FIFA shall play Association Football in
10 compliance with the Laws of the Game issued by IFAB. Only
IFAB may lay down and alter the Laws of the Game.
- 11 2. IFAB is composed of eight members; four members are
12 designated by FIFA and four by the British Associations.
- 13 3. The duties and responsibilities of IFAB are contained in special
regulations.
- 14 4. Each Member of FIFA shall play futsal in accordance with the
15 Futsal Laws of the Game, as issued by the FIFA Executive
Committee.⁹¹

16 202. Article 13 (“Member’s Obligations”) states that:

- 17 1. Members have the following obligations:
- 18 a) to comply fully with the Statutes, regulations, directives
19 and decisions of FIFA bodies at any time as well as the
20 decisions of the Court of Arbitration for Sport (CAS)
21 passed on appeal on the basis of art. 66 par. 1 of the
FIFA Statutes;
- 22 b) to ensure that their own members comply with the
23 Statutes, regulations, directives and decisions of FIFA
bodies;
- 24 c) to ratify statutes that are in accordance with the
25 requirements of the FIFA Standard Statutes;

26 ⁹⁰ [http://www.fifa.com/mm/document/affederation/generic/02/14/97/88/fifastatuten](http://www.fifa.com/mm/document/affederation/generic/02/14/97/88/fifastatuten013_e_neutral.pdf)
27 013_e_neutral.pdf, at p. 6 (last visited July 28, 2014).

28 ⁹¹ [http://www.fifa.com/mm/document/affederation/generic/02/14/97/88/fifastatuten](http://www.fifa.com/mm/document/affederation/generic/02/14/97/88/fifastatuten2013_e_neutral.pdf)
2013_e_neutral.pdf, at p. 8 (last visited July 28, 2014).

d) to respect the Laws of the Game;

e) to comply fully with all other duties arising from these Statutes and other regulations.

2. Violation of the above-mentioned obligations by any Member may lead to sanctions provided for in these Statutes.”⁹²

203. Article 18 (“Status of Leagues and other groups of Clubs”) states: “Leagues or any other groups affiliated to a Member of FIFA shall be subordinate to and recognised by that Member. The Member’s statutes shall define the scope of authority and the rights and duties of these groups. The statutes and regulations of these groups shall be approved by the Member.”

204. Article 52 (“Medical Committee”) states that “[t]he Medical Committee shall deal with all medical aspects of football.”

205. Article 69 (“Principle”) states that “[t]he Confederations, Members and Leagues shall agree to comply fully with any decisions passed by the relevant FIFA bodies which, according to these Statutes, are final and not subject to appeal. 2. They shall take every precaution necessary to ensure that their own members, Players and Officials comply with these decisions.”

206. Despite its power under its own rules and governing bodies neither FIFA nor the IFAB have undertaken changes to eliminate or minimize the epidemic of head injuries suffered by young players.

2. Other FIFA Materials Describing Its Operations and Confirming Its Duty to Protect Players.

207. FIFA, in a section of its website titled “Mission and Statutes,” in a subsection titled “What we stand for,” states the following:

OUR CLAIM

For the Game. For the World.

OUR MISSION

Developing football everywhere and for all

⁹² http://www.fifa.com/mm/document/affederation/generic/02/14/97/88/fifastatuten2013_e_neutral.pdf, at p. 12-13 (last visited July 28, 2014).

FIFA's primary objective is "to improve the game of football constantly and promote it globally in the light of its unifying, educational, cultural and humanitarian values, particularly through youth and development programmes."

We share the success of the FIFA World Cup™ to support football development projects in our 209 member associations across the globe. Football has flourished as a global game because of this support. With USD 550,000 going into these programmes each day, we are spending more than ever on football development.

Many of our members depend on this support to finance their day-to-day operations. It ensures that football can have a solid foundation throughout the world.

Organising inspiring tournaments

Our second objective is to organise international football competitions. FIFA's goal is to touch, unite and inspire the world through its competitions and events. We are best known for organising the biggest single-sport competition in the world: the FIFA World Cup™. The revenue from this one competition enables us to stage around 30 tournaments every four years, which serve to develop many aspects of the game, from women's and youth football to beach soccer, futsal and even the Interactive World Cup.

Caring about society and the environment

Football is much more than just a game. Its universal appeal means it has a unique power and reach which must be managed carefully. We believe that we have a **duty to society that goes beyond football: to improve the lives of young people and their surrounding communities, to reduce the negative impact of our activities and to make the most we can of the positives.**

...

This is the third crucial pillar of FIFA's mission: building a better future for all through football.⁹³

208. FIFA on its website has posted brochure titled "Our Commitment" which states the following:

OUR MISSION

'Develop the game, touch the world, build a better future.'

⁹³ <http://www.fifa.com/aboutfifa/organisation/mission.html> (July 28, 2014) (emphasis added).

1 Played by millions around the world, football is the heart and soul of
 2 FIFA and as the guardian of this most cherished game, we have a great
 3 responsibility. This responsibility does not end with organising the
 4 FIFA World Cup and the various other world cup competitions; it
 5 extends to safeguarding the Laws of the Game, to developing the game
 6 around the world and to bringing hope to those less privileged. This is
 7 what we believe is the very essence of fair play and solidarity.

8 We see it as our mission to contribute towards building a better future
 9 for the world by using the power and popularity of football. This
 10 mission gives meaning and direction to each and every activity that
 11 FIFA is involved in – football being an integrated part of our society.⁹⁴

12 209. FIFA continues:

13 **OUR APPROACH**

14 **Develop the game.** Improve the game of football constantly and
 15 promote it globally in the light of its unifying, educational, cultural and
 16 humanitarian values, particularly through youth and development
 17 programmes. Football development means investing in people and
 18 society at large. Football is a school of life.

19 **Touch the world.** Take world-class football action and passion at all
 20 levels to every corner of the planet through our 208 member
 21 associations. The broad range of competitions shows the many faces of
 22 football, spearheaded by the FIFA World Cup.

23 **Build a better future.** Football is no longer considered merely a
 24 global sport, but also a unifying force whose virtues can make an
 25 important contribution to society. We use the power of football as a
 26 tool for social and human development, by strengthening the work of
 27 dozens of initiatives around the globe to support local communities in
 28 the areas of peacebuilding, health, social integration, education and
 more.⁹⁵

210. FIFA continues:

21 **WHAT WE STAND FOR**

22 Our core values of authenticity, unity, performance and integrity are at
 23 the very heart of who we are.

24 ⁹⁴ http://www.fifa.com/mm/document/footballdevelopment/education/55/95/17/fifa_brandbroschuere_23x23, at 6 (last visited July 28, 2014).

25 ⁹⁵ http://www.fifa.com/mm/document/affederation/generic/02/14/97/88/fifastatuten2013_e_neutral.pdf, at p. 9 (last visited July 28, 2014).

Authenticity. We believe that football must remain a simple, beautiful game played by, enjoyed by and touching the lives of all people far and wide.

Unity. We believe it is FIFA's responsibility to foster unity within the football world and to use football to promote solidarity, regardless of gender, ethnic background, faith or culture.

Performance. We believe that FIFA must strive to deliver football of the highest quality and as the best possible experience, be it as a play, as a spectacle, or as a major cultural and social enabler throughout the world.

Integrity. We believe that, just as the game itself, FIFA must be a model of fair play, tolerance, sportsmanship and transparency.⁹⁶

211. Elsewhere on the website FIFA promises:

A CHANCE AND A CHALLENGE

'For the Game. For the World.' Reflects the core element of our mission and represents both a chance and challenge: a chance for us to contribute to making a difference to people's lives, and a challenge to balance this social element with our traditional competence of developing football, overseeing its rules and organising world-class competitions.

We see it as our duty to take on the social responsibility that comes hand in hand with our position at the helm of the world's most loved sport.⁹⁷

212. In a brochure titled "All About FIFA," FIFA states the following:

As world football's governing body, we take our duty to protect the game very seriously. Furthermore, our social responsibility is taking on an increasingly important role and in this, the third pillar of our mission, "build a better future," sends out a strong signal. **Our work to serve people, football and our society is not simply a promise but also a duty and part of our objective of protecting the game.**

Our three-pillar mission to 'develop the game, touch the world and build a better future' is now firmly established and we have further developed and implemented it with great dedication.

⁹⁶ http://www.fifa.com/mm/document/affederation/generic/02/14/97/88/fifastatuten2013_e_neutral.pdf, at p. 10 (last visited July 28, 2014).

⁹⁷ http://www.fifa.com/mm/document/affederation/generic/02/14/97/88/fifastatuten2013_e_neutral.pdf, at p. 13 (last visited July 28, 2014).

Of course, there is still much work to do and we face up to this challenge with unstinting commitment. Together, we can use this new dimension of football to build bridges and at the same time protect its core values.⁹⁸

213. FIFA further states, in a section titled “Member Associations” and subtitled “One big community,” that “[t]he 208 member associations are FIFA’s most important constituents and serve to extend the governing body’s reach around the world.”

214. FIFA further states:

The *sole responsibility* for the Laws of the Game lies with the International Football Association Board (IFAB), a body that convenes once a year to discuss the Laws. The IFAB is composed of FIFA (four votes) and, in recognition of their historic role in the formal codification of the game, the four British associations (England, Scotland, Wales and Northern Ireland with one vote apiece). (Emphasis added.)

215. In FIFA’s 2013 Financial Report it recognizes its duty to meet “Best Practice”: FIFA Has Demonstrated That It Is Prepared To Meet Best Practice.”

3. FIFA’s General Materials Relating to Medical Issues.

216. FIFA maintains various “Standing Committees,” one of which is a “Medical Committee” that FIFA states “shall deal with all medical aspects of football.” FIFA lists a Chairman, a Deputy Chairman, and 14 “Members,” one of which is Bert Mandelbaum listed as being from the “USA.”

217. FIFA’s website further states:

FIFA has also other bodies helping to fulfill its important mission. F-MARC aims to protect players’ health, prevent injury and maximise the health benefits of the game.

218. In a detailed brochure titled “All About FIFA,” FIFA states the following which recognizes its unique role in protecting players:

As an international federation, FIFA has taken a pioneering role in sports medicine.

⁹⁸ http://www.fifa.com/mm/document/fifafacts/organisation/02/13/11/06/03072013allaboutfifa_neutral.pdf, at 1 (last visited July 28, 2014) (emphasis added).

1 FIFA, through its Medical Assessment and Research Centre (F-
2 MARC), has been active in football medical research ever since 1994,
3 paying special attention to protecting players' health, prevention,
4 improving standards of care worldwide, environmental factors as well
as the education and training of physicians, physiotherapists, coaches
and players at all levels.

5 Implementing the "11+" injury prevention programme has led to a
6 considerable reduction of injuries, and the Pre-Competition Medical
Assessment has helped identify players at risk of sudden cardiac death.

7 The "11 for Health" programme goes one step further and uses football
8 to increase children's health knowledge in a structured, yet playful
manner. Publications, conferences and presentations, online
9 information and awareness campaigns disseminate relevant medical
expertise throughout the football family and the sports community. An
10 increasing number of FIFA Medical Centres of Excellence worldwide
offer superb medical care and promote prevention.

11
12 FIFA's anti-doping strategy aims to protect players' health while also
13 preserving the integrity of the game. Only doctors carry out doping
controls, and their worldwide network is part of the educational
14 approach in line with the World Anti-Doping Code.⁹⁹

15 **F. FIFA's Power to Influence**

16 219. FIFA's power and global influence is unparalleled in any sport. As FIFA states, "[i]t
17 is widely accepted that football is the most popular sport worldwide." And FIFA is richly rewarded
18 for presiding over that sport. In its 2013 Financial Report, FIFA reported yearly revenue of \$1.386
19 billion, and reserves of \$1.432 billion. FIFA stated that it received \$601 million alone for the
television rights to the recently concluded 2014 FIFA World Cup in Brazil.

20 220. FIFA's reach extends into the United States at all levels of soccer. Its influence is
21 symbolic, as well as contractual via the web of contracts in the form of bylaws that bind soccer
22 associations at all levels to follow the dictates of FIFA. In 2010, Don Garber, the chairman of the
23 United States' professional league Major League Soccer, stated that FIFA has "done an unbelievable
24 job of expanding the power and influence of the game and its deep connections – from youth through
25 the highest level of the World Cup." Mr. Garber continued that "[t]hey're the league office. [FIFA
26

27 ⁹⁹ <http://www.fifa.com/mm/document/fifafacts/organisation/02/13/11/06/03072013>
28 allaboutfifa_neutral.pdf, at pp. 40-41 (last visited July 28, 2014).

1 President] Sepp Blatter is the commissioner. They set the rules for all of us to play by, and the fact
 2 that you have a sport that's played throughout the world with millions and millions of participants
 3 and billions of fans, it requires a central body that is thinking about what is in the best interests of the
 4 sport and trying to connect all the dots amongst all those people who are engaged in it and to
 5 maximize the value for all ..."

6 221. FIFA frequently emphasizes its global responsibilities and duties extending far
 7 beyond elite players, including on medical issues and specifically on concussion issues. However,
 8 members of the U.S. Congress recently sent a letter to FIFA criticizing FIFA's deficient concussion
 9 protocols, recognizing FIFA's influence in the U.S. On July 15, 2014, several of them issued press
 10 releases describing the contents of a letter that they transmitted to FIFA's President. An exemplar
 11 press release states the following:

12 Today, U.S. Reps. Bill Pascrell, Jr. (D-NJ) and Thomas J. Rooney (R-
 13 FL), co-chairs of the Congressional Brain Injury Task Force, wrote to
 14 Fédération Internationale de Football Association (FIFA) President
 15 Joseph Blatter urging FIFA to implement protocols that would better
 16 protect its athletes from the dangers of traumatic brain injuries. The
 17 dangers of sports-related concussion were on full display during this
 year's World Cup, where several players were left in obvious pain and
 allowed to return to play almost immediately after receiving blows to
 the head.

18 "We strongly urge you to take action to adequately address TBI in your
 19 organization," the lawmakers wrote. "We witnessed the immediate
 20 effects of head injuries during this World Cup, but the long-term
 21 implications are rarely broadcast on international television. **Most**
 22 **importantly, we encourage FIFA to set a positive example for**
 23 **young fans who aim to emulate their favorite players. If young fans**
 24 **see their favorite players treat head injuries with such little regard,**
 25 **they too will not treat head injuries with the gravity they deserve.**
 Every concussion is brain damage and must be diagnosed and treated
 by appropriate medical personnel, who prioritize players' health,
 safety, and well-being." (Emphasis added.)

26 222. On a related note, on June 24, 2014, *BusinessWeek* reported that "[t]he 2014 FIFA
 27 World Cup match between the U.S. and Portugal produced another record-breaking ratings number
 28 for ESPN and Univision. The combined 24.7 million viewers – 18.2 million on ESPN and 6.5
 million on Univision, neither number official yet – would make it the most-watched soccer game in

1 U.S. history, just topping the 2010 World Cup final between Spain and the Netherlands. Soccer, at
 2 least in its World Cup form, can now make a claim to being the second-most popular televised sport
 3 in the U.S., behind only American-rules football.” Those viewers, however, saw an appalling
 4 abdication of FIFA’s responsibilities, as referenced above in the letter to FIFA from members of the
 5 U.S. Congress.

6 223. Moreover, on July 13, 2014, *Forbes.com* reported the following regarding FIFA’s
 7 influence on American youth by way of its massively-lucrative video-game licensing arrangement
 8 with Electronic Arts Inc. (“EA”):

9 But one overlooked factor that has spurred interest in soccer among
 10 Americans is the incredible popularity of Electronic Arts’ FIFA video
 11 game, which is the best-selling sports video game in the world and has
 12 sold more than 100 million copies since it launched in 1993. Credit
 13 Suisse forecasts unit sales of 11.3 million worldwide of FIFA 15 for
 the 12 months ending in March 2015. Sales of FIFA 16 are expected to
 hit 12.1 million. The game is the biggest annual release for \$3.6
 billion-in-sales Electronic Arts.

14 Youth soccer has been popular in the U.S. for decades, but FIFA
 15 exposes kids to the international game. Total unit sales of the series in
 16 the U.S. topped five million over the past two years, according to
 17 market research firm NPD. It still trails Madden NFL and NBA 2K
 among sports games in North America, but it is closing the gap
 quickly. Unit sales jumped 35% between 2010 and 2012 in the U.S.
 when they reached 2.6 million.

18 . . .

19 A 2012 ESPN Sports Poll found that soccer was the second most
 20 popular sport for those ages 12-24. FIFA video games were cited as a
 21 driving factor for the sport’s popularity among the younger generation
 22 in the study. The age group overlaps nicely with FIFA’s core audience
 23 which is 16-32, according to Nick Channon, a senior producer of the
 game at EA. These are the people that are fueling the interest in the
 sport and the nucleus of World Cup viewing parties. A recent survey of
 24 Americans by the Pew Research Center found that 24% of those 18-29
 had a strong interest in the World Cup.¹⁰⁰

25
 26
 27 ¹⁰⁰ <http://www.forbes.com/sites/kurtbadenhausen/2014/07/13/ea-sports-fifa-video-game-helps-fuel-interest-in-the-world-cup/>.
 28

224. Numerous concussion experts, newspaper editorial boards (including in California), and columnists have highlighted FIFA's irresponsibility and its deleterious effect on youth soccer players. For example, on June 23, 2014, the Editorial Board of the San Diego Union-Tribune, in an editorial titled "Soccer may be beautiful, but FIFA is a disgrace," after detailing other FIFA scandals, wrote that "the scandal that should most alarm American parents is FIFA's amazingly irresponsible attitude toward brain injuries ... Shades of the 20th-century National Football League." The Editorial Board continued, making the direct correlation between FIFA and youth soccer in the United States and California, and stated that "FIFA's blitheness toward concussions sends a message that resonates around the world – including with soccer authorities in the United States, where girls soccer trails only boys football as a source of concussions." The Editorial Board continued that "[e]ven though it's long been established that children are particularly susceptible to brain injuries, it wasn't until this April that the California State Soccer Association-South – the official youth and adult wing of the United States Soccer Federation and United States Youth Soccer – adopted tough rules preventing players with concussions from returning to competition without written clearance from a licensed health provider. In 2010 – the last time the World Cup was played – a search of Cal South's densely detailed website didn't turn up a single mention of concussions." The Editorial Board concluded that "[w]hen it comes to kids and tackle football, this understanding of the risks has changed how parents think. It's why participation in Pop Warner football is declining. We need this understanding in non-American football as well – starting with those in charge, from FIFA to the smallest youth league."

225. On July 15, 2014, *The Associated Press*, in an article titled "US Concussion Expert: World Cup Sets Bad Example," reported that "World Cup organizers repeatedly failed to follow their own concussion protocol and then failed to take advantage of the international interest in the tournament to teach soccer fans and young players about the dangers of head injuries, concussion expert Chris Nowinski said Tuesday." The article quoted Mr. Nowinski as stating that "I'm worried about how many kids emulate these athletes. It wasn't just one athlete hurt; it was one multiplied by 1 million. They didn't even use a bully pulpit and say: 'This is unacceptable.'" Mr. Nowinski

1 continued that “[i]t was a great teaching point: Immediately after the injury, you can’t leave it up to
2 the athlete. Some of these concussions, they clearly weren’t able to make decisions for themselves.”

3 226. On July 16, 2014, *The New York Times*, an article titled “FIFA’s Dazed and Dated
4 Attitude,” reported that “Dr. Robert Cantu, a leading expert in sports-related concussions,” stated
5 that ““FIFA has had the eyes of the world look at them and has rather unanimous criticism from
6 concussion specialists in this country, who were kind of appalled at the way they handled
7 concussions. I do think it’s time for them to change.”

8 227. On July 14, 2014, the Editorial Board of *The New York Times*, in an editorial titled
9 “Cleaning Up After the World Cup,” addressed FIFA’s numerous scandals, including its mishandling
10 of concussion issues, and wrote that “[i]n all, the World Cup demonstrated why football, a.k.a.
11 soccer, is the most global and popular of sports. And why it is time for FIFA to measure up to the
12 sport it governs.” The Editorial Board continued that “[c]learly, it is time for soccer to adopt safety
13 measures to spot concussions ... Soccer is a hugely important force in the world today. Its stewards
14 should do everything in their power to keep it clean, safe and fair.”

15 228. On November 8, 2014, a columnist in *The Ottawa Citizen*, in a column titled “Soccer
16 must address head hits,” wrote that “[g]uidelines from FIFA are totally insufficient and I can find
17 nothing in the laws of the game that addresses head injuries. It’s high time FIFA stepped forward
18 with definitive rules that must be followed by soccer worldwide.”

19 **G. Each of the Defendants Have Failed to Provide Adequate Concussion**
20 **Management**

21 **4. FIFA.**

22 **a. FIFA Has Knowledge of Consensus Best Practices.**

23 229. FIFA participated in the First International Conference on Concussion in Sport in
24 Vienna on November 2 and 3, 2001, which resulted in the publication of the Vienna Protocol in early
25 2002.

230. FIFA documented its role in the First International Conference on Concussion in Sport on its website and acknowledged that the conference would result in a “unanimous decision” to develop a “concussion protocol, global in scope”:¹⁰¹

FIFA, together with the International Ice Hockey Federation (IIHF) and the International Olympic Committee (IOC), invited medical experts from around the world specializing in the area of brain injury to present their research knowledge and experience. Significant progress was made in consensus for the development of a concussion protocol, global in scope, led by a core group of the medical experts working with the sporting bodies.

A unanimous decision by the sport medical representatives in attendance to pursue the development of the Concussion protocol was made, which essentially will address the following areas:

1. Concussion identification
2. Concussion evaluation
3. Implementation of new concussion research techniques
4. Concussion management, including immediate assessment, return to play and rehabilitation
5. Concussion prevention.

231. Following the Vienna Conference, FIFA acknowledged the importance of the creation of common guidelines which were to be implemented at all levels of the game and in all FIFA member associations. Professor Jiri Dvorak, a member of FIFA’s Sports Medical Committee, stated:¹⁰²

It is now crucial to embody these findings in common guidelines as well as to define criteria for the decision if and when an athlete is to be allowed to resume his sporting activities.

“Furthermore, it is important to reach global uniformity on these issues and to make the guidelines and recommendations available at every level of the game,” added Prof Dvorak.

A core group of experts is expected to work out a uniform phrasing of these definitions and guidelines within the foreseeable future.

¹⁰¹ <http://www.fifa.com/aboutfifa/footballdevelopment/medical/news/newsid=79906/index.html> (last visited Aug. 7, 2014).

¹⁰² *Id.*

232. FIFA organized and hosted the 3rd and 4th International Conferences on Concussion in Sport in Zurich – FIFA’s own backyard.

233. In November 2008, FIFA President Sepp Blatter opened the 3rd International Conference on Concussion in Sport conference. FIFA’s website states:¹⁰³

Concussion in sport is a considerable concern of sport organisations. The football public remembers when Chelsea’s goalkeeper Peter Cech suffered a severe head injury from the collision with the knee of a counterpart. Less dramatic, but as important concussion issues were discussed at the 3rd International Conference at the Home of FIFA in Zurich.

FIFA, the International Olympic Committee, the International Ice Hockey Federation, and the International Rugby Board organised this third conference that began with Vienna (2001) and Prague (2004). Once more, international leaders and experts in the field from Europe, Australia, the US and Canada came to present the latest findings on this difficult injury to sports physicians from all over the world. After FIFA President Joseph S. Blatter opened the conference, stressing the importance of learning more on this important matter, the discussion focused on different topics.

234. FIFA also hosted the 4th International Conference on Concussion in Sport in Zurich in November 2012. Again, FIFA summarized the conference in a news article on its website.¹⁰⁴

Top international sports experts representing the IOC, FIFA and several other international sports federations met at the Home of FIFA in Zurich on 1 and 2 November 2012 for the Fourth International Consensus Conference on Concussion in Sport. The objective of the two-day event was to discuss and find a consensus on the best way to manage and prevent cases of concussion in sport.

Professor Jiri Dvorak, FIFA’s Chief Medical Officer said: “What we are expecting is to develop very practical, simple, easy to use tools that could be applied for coaches, for the paramedical personnel on the sidelines and in grassroots, where there is little medical attention. So we’re trying to develop simple educational materials for all involved in football and disseminate them through FIFA development programmes. With such powerful partners like FIFA, the IIHF, the IRB, the Equestrian Federation and the IOC we can make a big impact.

¹⁰³ <http://www.fifa.com/aboutfifa/footballdevelopment/medical/news/newsid=938876/index.html> (last visited Aug. 7, 2014).

¹⁰⁴ <http://www.fifa.com/aboutfifa/footballdevelopment/medical/news/newsid=1816858/>.

b. FIFA Fails to Adopt the Consensus Guidelines Promulgated by the International Conferences on Concussion in Sport.

235. Despite FIFA's documented attendance of the International Conferences on Concussion in Sport – twice held in Zurich, FIFA's own backyard – FIFA has failed to adopt the internationally accepted guidelines set forth in 2002 in the Vienna Protocol, reaffirmed and explained in the 2005 Prague Protocol and expounded upon again in the 2009 and 2013 Zurich Protocols.

236. A recent headline characterizes FIFA's lack of response to the concussion issues in soccer:¹⁰⁵

Another World Cup Match, Another Ugly Concussion. If FIFA Cared, Here's How They'd Fix This

Another World Cup match. Another bad head injury. And another case of FIFA's leaders watching – and doing nothing.

Early in Sunday's World Cup final, Germany's Christoph Kramer slammed his head into the shoulder of Argentina's Ezequiel Garay. It was a brutal blow – you can see it here – and knocked Kramer, spinning, face-first into the ground. He also appeared to lose consciousness, displaying classic brain injury symptoms known as “fencing response.”

Let's say we were watching football, not fútbol. If a similar sequence had unfolded in the Super Bowl, Kramer would've been immediately withdrawn from the game and not allowed to return.

But after some quick treatment, Kramer stayed and played on. And on. And on – about fifteen minutes in total, before dazed and slumping, he had to be helped off the field.

If this seems familiar, well, we've seen it before in this World Cup.

- Three weeks ago, Uruguay's Alvaro Pereira overruled his team doctor and stayed on the field after being knocked out.
- And last week, Argentina's Javier Mascherano returned almost immediately from a blow to the head that left him staggering to the ground.

Don't blame Kramer, Pereira, or any player for wanting to gut out their injuries. In the moment, they almost certainly want to stay on – to help

¹⁰⁵ <http://www.forbes.com/sites/dandiamond/2014/07/13/another-world-cup-match-another-ugly-concussion-if-fifa-cared-heres-how-theyd-fix-this/>.

1 their team, to take part in the greatest professional moment of their
2 careers.

3 Blame FIFA's antiquated and toothless concussion protocols, which
4 can't protect players from themselves.

5 And the players know it, which is why they're desperately calling for
6 reforms. FIFPro, the players union, urgently appealed – after the
7 Pereira injury three weeks ago – for talks and “immediate assurances
8 that FIFA can guarantee the safety of the players, which must be
9 priority number one, for the remainder of this tournament and beyond.”

10 But since then, FIFA has done nothing. (Emphasis added.)

11 237. One sports commentator called FIFA's response to concussions in soccer as
12 “barbaric”:

13 While head injuries have become a buzz topic in American sports,
14 many feel it's not nearly a high enough priority for FIFA and the
15 international soccer community. Protocols are vague and inconsistent.
16 Players have returned to games quickly after suffering injuries. And
17 sidelines lack independent observers with any sort of authority.

18 “It's barbaric. The way FIFA has turned an eye to head injuries, it's
19 1950s-ish,” said ESPN analyst Taylor¹⁰⁶ Twellman, the former
20 University of Maryland and MLS star whose career was cut short due
21 to concussions. “It's just mind-boggling.... FIFA acts like it doesn't
22 exist.” (Emphasis added.)¹⁰⁷

23 238. It is clear that FIFA has failed to require (much less explain) the appropriate
24 consensus guidelines. In comparison to the most recent Zurich II Protocol and other guidelines and
25 publications of the time period from 2002 to the present, FIFA has failed to implement, and require
26 its member associations to implement, the following best practices of concussion management as
27 established by the International Conferences on Concussion in Sport:

- 28 • A rule that a player may not return to play on the same day of a
concussion;
- A mandatory 24 hour stepwise return to play guideline which
accounts for the fact that a day is needed between return to play
steps and that typically a week of asymptomatic time is needed

¹⁰⁶ http://www.washingtonpost.com/sports/dcunited/world-cup-2014-many-say-fifa-hasnt-done-enough-to-treat-concussions/2014/06/24/50c4535a-fbca-11e3-b8bf-54b8afb537b6_story.html.

¹⁰⁷ <http://theconcussionblog.com/tag/taylor-twellman/>.

1 to resolve symptoms relating to a concussion prior to return to
2 play;

- 3 • Formal baseline testing regardless of the age or level of
4 performance of the players and neuropsychological testing to
5 evaluate injury;
- 6 • Require that a player with a concussion or a suspected
7 concussion be evaluated, managed, and cleared by medical
8 personnel with specific expertise in concussion diagnosis,
9 treatment, and management; and
- 10 • Rule changes to account for proper concussion management.

11 239. FIFA has also failed to implement and enforce, or require its member associations to
12 implement and enforce, the following best practices of concussion management for child and
13 adolescent athletes as established by the International Conferences on Concussion in Sport which:

- 14 • Require a different concussion symptom checklist for children
15 below the age of 13;
- 16 • Require that concussion treatment and evaluation involve
17 parental input;
- 18 • Require utilization of the SCAT3 sideline concussion
19 assessment tool specifically designed for children aged 5-12;
- 20 • Require that a child should not return to play before the child
21 has returned to school successfully; and
- 22 • Require a more conservative return to play approach for
23 children.

24 240. FIFA's website makes no mention of the special considerations in concussion
25 management for child and adolescent athletes particularly that children should not be returned to play
26 until completely symptom-free, which may require a longer time frame than for adults and a more
27 conservative return to play approach for children is recommended.¹⁰⁸

28 ¹⁰⁸ P. McCrory et al., *Consensus statement on concussion in sport: the 4th International
Conference on Concussion in Sport held in Zurich, November 2012*, 47 BRIT. J. SPORTS MED. 250
(2013), at 5, available at <http://bjsm.bmj.com/content/47/5/250.full.pdf+html>.

1. FIFA Fails to Require a Stepwise Return to Play Protocol Which Prohibits Same Day Return to Play.

241. FIFA's failure to implement or enforce consensus guidelines regarding return to play protocol and a rule prohibiting returning to play following a concussion was magnified during the 2014 World Cup in Brazil during which multiple players, including Germany's Christoph Kramer, were visibly knocked unconscious and yet were permitted to continue playing in the same game. As reported by the New York Times:¹⁰⁹

Of all the lasting images from the 2014 World Cup, the officials who run FIFA, soccer's governing body, should be forced to remember one, above all: Germany's Christoph Kramer staggering around the field in the final, glassy-eyed and dazed, like a sleepwalker.

242. Although undiscernible during the 2014 World Cup, consensus was reached in 2002 – and reinforced with each subsequent International Consensus Statement – that athletes suffering concussion symptoms should never be returned to play in the same game. In addition, consensus was also reached in 2002 that coaches, players, trainers, and physicians should follow a systematic return to play policy that includes systematic and graded return to exertion following injury, systematic reevaluation of symptoms following each exertional state, and a collective understanding that the patient is completely asymptomatic at rest, asymptomatic with exertion, and has intact neurocognitive performance prior to final clearance. The best practice consensus guideline has continually been reinforced since the Vienna Protocol.

243. FIFA has failed to implement or require the implementation of the consensus return to play protocols set forth in 2002 Vienna Protocol – and updated with the Prague, Zurich, and Zurich II Protocols. For example, the Vienna Protocol recommended specific return to play guidelines that continue to be followed today:

When a player shows ANY symptoms or signs of a concussion:

- (1) The player should not be allowed to return to play in the current game or practice.

¹⁰⁹ http://www.nytimes.com/2014/07/16/sports/soccer/world-cup-2014-christoph-kramers-head-injury-brings-fifas-problem-to-the-forefront.html?_r=0 (last visited Aug. 7, 2014).

(2) The player should not be left alone; and regular monitoring for deterioration is essential.

(3) The player should be medically evaluated after the injury.

Return to play must follow a medically supervised stepwise process. A player should never return to play while symptomatic. 'When in doubt, sit them out!'

244. The Vienna Protocol also recommended a return to play stepwise process as follows:

It was the consensus of the CISG that a structured and supervised concussion rehabilitation protocol is conducive to optimal injury recovery and safe and successful return to play. The rehabilitation principles were common to all identified programmes and are outlined below. Important principles state that the athlete be completely asymptomatic and have normal neurological and cognitive evaluations before the start of the rehabilitation programme. Therefore, the more prolonged the symptom duration, the longer the athlete will have sat out. The athlete will then proceed stepwise with gradual incremental increases in exercise duration and intensity, and pause or backtrack with any recurrence of concussive symptoms. It is appreciated that, although each step may take a minimum of one day, depending on the duration of symptoms, proceeding through each step may take longer in individual circumstances.

245. The Vienna Protocol also provides that return to play after a concussion follows a stepwise process:

- (1) No activity, complete rest. Once asymptomatic, proceed to level.
- (2) Light aerobic exercise such as walking or stationary cycling.
- (3) Sport specific training – for example, skating in hockey, running in soccer.
- (4) Non-contact training drills.
- (5) Full contact training after medical clearance.
- (6) Game play.

With this stepwise progression, the athlete should continue to proceed to the next level if asymptomatic at the current level. If any symptoms occur after concussion, the patient should drop back to the previous asymptomatic level and try to progress again after 24 hours.

246. The necessity of a stepwise return to play protocol has been reinforced as recently as 2013. Zurich II stated:¹¹⁰

Return to play protocol following a concussion follows a stepwise process ... With this stepwise progression, the athlete should continue to proceed to the next level if asymptomatic at the current level. Generally, each step should take 24 h so that an athlete would take approximately one week to proceed through the full rehabilitation protocol once they are asymptomatic at rest and with provocative exercise. If any postconcussion symptoms occur while in the stepwise programme, then the patient should drop back to the previous asymptomatic level and try to progress again after a further 24 h period of rest has passed.

Zurich II included the following chart:¹¹¹

Graduated Return-to-Play Protocol:

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
1. No activity	Symptom limited physical and cognitive rest	Recovery
2. Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum permitted heart rate No resistance training	Increase HR
3. Sport-specific exercise	Skating drills in ice hockey, running drills in soccer. No head impact activities	Add movement
4. Non-contact training drills	Progression to more complex training drills, eg, passing drills in football and ice hockey May start progressive resistance training	Exercise, coordination and cognitive load
5. Full-contact practice	Following medical clearance participate in normal training activities	Restore confidence and assess functional skills by coaching staff
6. Return to play	Normal game play	

¹¹⁰ Zurich II Protocol, at 4.

¹¹¹ *Id.*

1 247. Zurich II explained that a single return to play paradigm should be used for all
2 athletes and that formal neuropsychological testing should be used in high-risk sports regardless of
3 age or level of competition, explaining:¹¹²

4 All athletes regardless of level of participation should be managed
5 using the same treatment and return to play paradigm. The available
6 resources and expertise in concussion evaluation are of more
7 importance in determining management than a separation between elite
8 and non-elite athlete management. Although formal NP testing may be
beyond the resources of many sports of individuals, it is recommended
that, in all organised high-risk sports, consideration be given to having
this cognitive evaluation, regardless of the age or level of performance.

9 248. FIFA's website recommends that "[I]f you feel a little out of sorts, but think you can
10 still play, that may not be a good idea ... The safest is: 'when in doubt, keep out.'"¹¹³ Despite this
11 recommendation, which leaves ultimate discretion to a player who may or may not know if they have
12 been concussed, FIFA does not currently require that a player sustaining a concussion or
13 experiencing concussion symptoms be removed and kept out of the game or practice for 24 hours.
14 FIFA's failure to implement and enforce a rule requiring that players suffering concussion symptoms
15 should never be returned to play in the same game also is against best practices.

16 249. Similarly, while FIFA's website provides an informational "step-by-step guide for
17 return to play following a concussion" which will "take you gradually back to play,"¹¹⁴ FIFA does
18 not currently require, and since 2002 has never required, the use of this return to play protocol in
19 contravention of consensus best practice guidelines.

20 **2. FIFA Fails to Require Formal Baseline and/or Post-Injury** 21 **Neurocognitive Testing of Players.**

22 250. The International Consensus Statements provide that neuropsychological testing is
23 one of the "cornerstones" of appropriate concussion management and contributes significantly to
24 both understanding the injury and management of the individual.

25 ¹¹² *Id.* at 5.

26 ¹¹³ [http://www.fifa.com/aboutfifa/footballdevelopment/medical/playershealth/injuries](http://www.fifa.com/aboutfifa/footballdevelopment/medical/playershealth/injuries/commoninjuries/head.html)
27 /[commoninjuries/head.html](http://www.fifa.com/aboutfifa/footballdevelopment/medical/playershealth/injuries/commoninjuries/head.html) (last visited Aug. 7, 2014).

28 ¹¹⁴ [http://www.fifa.com/aboutfifa/footballdevelopment/medical/playershealth/](http://www.fifa.com/aboutfifa/footballdevelopment/medical/playershealth/injuries/commoninjuries/head.html)
/[injuries/commoninjuries/head.html](http://www.fifa.com/aboutfifa/footballdevelopment/medical/playershealth/injuries/commoninjuries/head.html) (last visited Aug. 7, 2014).

251. For example, the Vienna Protocol provided that neuropsychological testing “has shown to be of value and continues to contribute significant information in concussion evaluation It has been shown that cognitive recovery may precede or follow resolution of clinical symptoms, suggesting that the assessment of cognitive function should be an important component in any return to play protocol.”

252. The importance of neuropsychological testing has been reinforced with each subsequent International Consensus Statement. For example, the Zurich II Protocol recommends that “all athletes should have a clinical neurological assessment (including assessment of their cognitive function) as part of their overall management,” and that all high-risk sports, regardless of the age or level of performance, have formal baseline neuropsychological screening.¹¹⁵

253. FIFA’s website fails to mention, much less require, formal baseline testing or the use of neuropsychological testing to assess injury. Further, FIFA fails to mention that in the absence of neuropsychological testing, a more conservative return to play approach may be appropriate.

254. FIFA’s failure to require formal baseline testing and to utilize neuropsychological testing is in contravention of consensus best practices. Without a formal baseline, it is very difficult for a physician to determine when a patient has recovered. And returning a player to play before they are fully recovered negligently puts them at risk for permanent brain injury.

3. FIFA Fails to Require that Players’ Concussions Be Managed Onsite by Medical Personnel with Specific Expertise in Concussion Diagnosis, Treatment, and Management.

255. The Zurich II Protocol provides the following in regards to medical evaluation of when a player shows any feature of a concussion:¹¹⁶

On-field or sideline evaluation of acute concussion

When a player shows ANY features of a concussion:

A. The player should be evaluated by a physician or other licensed healthcare provider onsite using standard emergency management principles and particular attention should be given to excluding a cervical spine injury.

¹¹⁵ Zurich II Protocol, at 3.

¹¹⁶ *Id.*

- B. The appropriate disposition of the player must be determined by the treating healthcare provider in a timely manner. If no healthcare provider is available, the player should be safely removed from practice or play and urgent referral to a physician arranged.
- C. Once the first aid issues are addressed, an assessment of the concussive injury should be made using the SCAT3 or other sideline assessment tools.
- D. The player should not be left alone following the injury and serial monitoring for deterioration is essential over the initial few hours following injury.
- E. A player with diagnosed concussion should not be allowed to RTP on the day of injury.

256. While the FIFA website recommends “full contact training after medical clearance,” FIFA does not require or enforce a rule requiring that a player be evaluated by a physician on the sideline and before returning to play.

257. Further, while the FIFA website recommends the use of the SCAT3 sideline evaluation test, it does not indicate or require that a physician or other licensed healthcare provider administer the test. FIFA’s website states: “[H]ave this sideline test in your pocket to check if a player has suffered a concussion.”¹¹⁷ However, it is unclear who is supposed to administer the test and when the test is to be administered. In fact, the FIFA website implies that players themselves are responsible for administering the SCAT3 test to determine symptoms and the presence of concussion. FIFA’s website states:¹¹⁸

In important matches or with minor incidents, you might be very reluctant to do so. A short touchline assessment helps in the decision. The “Pocket SCAT” entails symptoms, questions and a balance test. If any of the described signs or symptoms is present, you might have a concussion and need to be removed from play. As a general rule, use this test for all head injuries.

258. FIFA’s failure to implement a policy requiring administration of a standardized sideline evaluation tool such as the SCAT3 is in contravention of best practices, including the Zurich

¹¹⁷ <http://www.fifa.com/aboutfifa/footballdevelopment/medical/playershealth/injuries/commoninjuries/head.html> (last visited Aug. 7, 2014).

¹¹⁸ *Id.*

II Protocol, which requires that a “player should be evaluated by a physician or other licensed healthcare provider onsite....”

259. FIFA’s failure to require physician involvement and that a player with concussion symptoms be seen and cleared by medical personnel who is experienced in concussion is in contravention of best practices.

260. Because of FIFA’s power via “Laws of the Game,” it knew that its failure to adopt best practices for concussion management would have the effect of the organizations that follow FIFA Rules not considering best concussion management practices to be part of the Laws of the Game.

5. U.S. Soccer

a. U.S. Soccer Has Knowledge of Consensus Best Practices.

261. U.S. Soccer’s website states: “[A]s the science of evaluating and managing concussions has advanced, key findings emphasize the need for education of players, their families, coaches, medical staffs and the public at large on the signs and symptoms of concussion.” Further, “there is also a critical need for early identification and proper management of concussion.”¹¹⁹

262. U.S. Soccer has also created a “U.S. Soccer Concussion Management Program” to “provide state of the art education, evaluation and management of concussions among *national team players*” which includes “pre-injury baseline testing with comprehensive post-injury follow-up evaluations and return to play protocols.”¹²⁰

263. The program consists of a “Concussion Testing and Management Process” for U.S. Soccer National Teams consisting of: baseline testing of all players during their first national team camp; concussion education; emergency assessment of athletes; stabilizing and transporting the athlete if needed; on field evaluation procedures; removing a player immediately from participation if concussion is suspected; procedures for contacting parents and U.S. Soccer medical staff; training

¹¹⁹ <http://www.ussoccer.com/about/federation-services/sports-medicine> (last visited Aug. 21, 2014).

¹²⁰ *Id.* (emphasis added).

1 room evaluations; post-concussion neurological tests; procedures to consult neuropsychologists and
 2 physicians post-injury; and a graded return to play protocol.¹²¹

3 **b. U.S. Soccer Fails to Adopt the Consensus Guidelines Promulgated by the**
 4 **International Conferences on Concussion in Sport.**

5 264. Zurich II explained that a single treatment and return to play paradigm should be used
 6 for all athletes and that formal neuropsychological testing should be used in high-risk sports
 7 regardless of age or level of competition, explaining:¹²²

8 All athletes regardless of level of participation, should be managed
 9 using the same treatment and RTP paradigm. The available resources
 10 and expertise in concussion evaluation are of more importance in
 11 determining management than a separation between elite and non-elite
 12 athlete management. Although formal NP testing may be beyond the
 13 resources of many sports or individuals, it is recommended that, in all
 14 organised high-risk sports, consideration be given to having this
 15 cognitive evaluation, regardless of the age or level of performance.

16 265. U.S. Soccer's "U.S. Soccer Concussion Management Program" is applicable only to
 17 U.S. Soccer's elite, national team players despite the best practice consensus that "all athletes
 18 regardless of level of participation, should be managed using the same treatment and RTP
 19 paradigm."

20 266. Despite knowledge of consensus guidelines as reflected in its "U.S. Soccer
 21 Concussion Management Program" for elite, national team players, U.S. Soccer has failed to
 22 implement or enforce the internationally accepted guidelines set forth in 2002 in the Vienna
 23 Protocol, reaffirmed and explained in the 2005 Prague Protocol and expounded upon again in the
 24 2009 and 2013 Zurich Protocols "regardless of level of participation."

25 267. It is clear that U.S. Soccer has failed to implement or enforce the appropriate
 26 consensus guidelines for players "regardless of level of participation." In comparison to the most
 27 recent Zurich II Protocol and other guidelines and publications of the time period from 2002 to the
 28 present, U.S. Soccer has failed to implement or enforce the following best practices of concussion
 management as established by the International Conferences on Concussion in Sport:

¹²¹ *Id.*

¹²² *Id.* at 5.

- A rule that a player may not return to play on the same day of a concussion;
- A mandatory 24 hour stepwise return to play guideline which accounts for the fact that a day is needed between return to play steps and that typically a week of asymptomatic time is needed to resolve symptoms relating to a concussion prior to return to play;
- Formal baseline testing regardless of the age or level of performance of the players and neuropsychological testing to evaluate injury;
- Require that a player with a concussion or a suspected concussion be evaluated, managed, and cleared by medical personnel with specific expertise in concussion diagnosis, treatment, and management; and
- Rule changes to account for proper concussion management.

268. U.S. Soccer has also failed to implement or enforce the following best practices of concussion management for child and adolescent athletes as established by the International Conferences on Concussion in Sport which:

- Require a different concussion symptom checklist for children below the age of 13;
- Require that concussion treatment and evaluation involve parental input;
- Require utilization of the SCAT3 sideline concussion assessment tool specifically designed for children aged 5-12;
- Require that a child should not return to play before the child has returned to school successfully; and
- Require a more conservative return to play approach for children.

269. U.S. Soccer's website makes no mention of the special considerations in concussion management for child and adolescent athletes particularly that children should not be returned to play until completely symptom-free, which may require a longer time frame than for adults and a more

conservative return to play approach for children is recommended.¹²³ U.S. Soccer has also failed to address in any material concerns about the requests for change to concussion policies on national broadcasts, including specific commentary by former USMNT and New England Revolution player Taylor Twellman whose career was cut short by multiple concussions and improper treatment using FIFA and U.S. Soccer protocols.

4. U.S. Soccer Fails to Require a Stepwise Return to Play Protocol Which Prohibits Same Day Return to Play.

270. Consensus was reached in 2002 – and reinforced with each subsequent International Consensus Statement – that athletes suffering concussion symptoms should never be returned to play in the same game. In addition, consensus was also reached in 2002 that coaches, players, trainers, and physicians should follow a systematic return to play policy that includes systematic and graded return to exertion following injury, systematic reevaluation of symptoms following each exertional state, and a collective understanding that the patient is completely asymptomatic at rest, asymptomatic with exertion, and has intact neurocognitive performance prior to final clearance. The best practice consensus guideline has continually been reinforced since the Vienna Protocol.

271. U.S. Soccer has failed to implement or enforce the consensus return to play protocols for non-national team players as set forth in 2002 Vienna Protocol – and updated with the Prague, Zurich, and Zurich II Protocols. For example, the Vienna Protocol recommended specific return to play guidelines that continue to be followed today:

When a player shows ANY symptoms or signs of a concussion:

- (1) The player should not be allowed to return to play in the current game or practice.
- (2) The player should not be left alone; and regular monitoring for deterioration is essential.
- (3) The player should be medically evaluated after the injury.

Return to play must follow a medically supervised stepwise process. A player should never return to play while symptomatic. ‘When in doubt, sit them out!’

¹²³ <http://www.ussoccer.com/about/federation-services/sports-medicine> (last visited Aug. 21, 2014).

1 272. The Vienna Protocol also recommended a return to play stepwise process as follows:

2 It was the consensus of the CISG that a structured and supervised
3 concussion rehabilitation protocol is conducive to optimal injury
4 recovery and safe and successful return to play. The rehabilitation
5 principles were common to all identified programmes and are outlined
6 below. Important principles state that the athlete be completely
7 asymptomatic and have normal neurological and cognitive evaluations
8 before the start of the rehabilitation programme. Therefore, the more
9 prolonged the symptom duration, the longer the athlete will have sat
10 out. The athlete will then proceed stepwise with gradual incremental
11 increases in exercise duration and intensity, and pause or backtrack
12 with any recurrence of concussive symptoms. It is appreciated that,
13 although each step may take a minimum of one day, depending on the
14 duration of symptoms, proceeding through each step may take longer
15 in individual circumstances.

16 273. The Vienna Protocol also provides that return to play after a concussion follows a
17 stepwise process:

- 18 (1) No activity, complete rest. Once asymptomatic, proceed to
19 level.
- 20 (2) Light aerobic exercise such as walking or stationary cycling.
- 21 (3) Sport specific training – for example, skating in hockey,
22 running in soccer.
- 23 (4) Non-contact training drills.
- 24 (5) Full contact training after medical clearance.
- 25 (6) Game play.

26 With this stepwise progression, the athlete should continue to proceed
27 to the next level if asymptomatic at the current level. If any symptoms
28 occur after concussion, the patient should drop back to the previous
29 asymptomatic level and try to progress again after 24 hours.

30 274. The necessity of a stepwise return to play protocol has been reinforced as recently as
31 2013. Zurich II stated:¹²⁴

32 Return to play protocol following a concussion follows a stepwise
33 process ... With this stepwise progression, the athlete should continue
34 to proceed to the next level if asymptomatic at the current level.
35 Generally, each step should take 24 h so that an athlete would take

36 ¹²⁴ Zurich II Protocol, at 4.

approximately one week to proceed through the full rehabilitation protocol once they are asymptomatic at rest and with provocative exercise. If any postconcussion symptoms occur while in the stepwise programme, then the patient should drop back to the previous asymptomatic level and try to progress again after a further 24 h period of rest has passed.

275. Zurich II included the following chart:¹²⁵

Graduated Return-to-Play Protocol:

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
1. No activity	Symptom limited physical and cognitive rest	Recovery
2. Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum permitted heart rate No resistance training	Increase HR
3. Sport-specific exercise	Skating drills in ice hockey, running drills in soccer. No head impact activities	Add movement
4. Non-contact training drills	Progression to more complex training drills, eg, passing drills in football and ice hockey May start progressive resistance training	Exercise, coordination and cognitive load
5. Full-contact practice	Following medical clearance participate in normal training activities	Restore confidence and assess functional skills by coaching staff
6. Return to play	Normal game play	

276. U.S. Soccer does not currently require that players sustaining a concussion or experiencing concussion symptoms be removed and unable to return to the game or practice. U.S. Soccer's failure to implement or enforce a rule requiring that players suffering concussion symptoms should never be returned to play in the same game also is against best practices.

277. Similarly, U.S. Soccer does not currently require or enforce, and since 2002 has never required or enforced, the use of a return to play protocol "regardless of level of participation" in contravention of consensus best practice guidelines.

¹²⁵ *Id.*

5. U.S. Soccer Fails to Require Formal Baseline and/or Post-Injury Neurocognitive Testing of Players.

278. The International Consensus Statements provide that neuropsychological testing is one of the “cornerstones” of appropriate concussion management and contributes significantly to both understanding the injury and management of the individual.

279. For example, the Vienna Protocol provided that neuropsychological testing “has shown to be of value and continues to contribute significant information in concussion evaluation It has been shown that cognitive recovery may precede or follow resolution of clinical symptoms, suggesting that the assessment of cognitive function should be an important component in any return to play protocol.”

280. The importance of neuropsychological testing has been reinforced with each subsequent International Consensus Statement. For example, the Zurich II Protocol recommends that “all athletes should have a clinical neurological assessment (including assessment of their cognitive function) as part of their overall management,” and that all high-risk sports, regardless of the age or level of performance, have formal baseline neuropsychological screening.¹²⁶

281. U.S. Soccer does not require formal baseline testing or the use of neuropsychological testing to assess injury “regardless of the age or level of performance.” Further, U.S. Soccer fails to mention that in the absence of neuropsychological testing, a more conservative return to play approach may be appropriate.

282. U.S. Soccer’s failure to require formal baseline testing and to utilize neuropsychological testing for all players “regardless of the age or level of performance” is in contravention of consensus best practices. Without a formal baseline, it is very difficult for a physician to determine when a patient has recovered. And returning a player to play before they are fully recovered negligently puts them at risk for permanent brain injury.

¹²⁶ *Id.*

6. **U.S. Soccer Fails to Require that Players' Concussions Be Managed Onsite by Medical Personnel with Specific Expertise in Concussion Diagnosis, Treatment, and Management.**

283. The Zurich II Protocol provides the following in regards to medical evaluation of when a player shows any feature of a concussion:¹²⁷

On-field or sideline evaluation of acute concussion

When a player shows ANY features of a concussion:

F. The player should be evaluated by a physician or other licensed healthcare provider onsite using standard emergency management principles and particular attention should be given to excluding a cervical spine injury.

G. The appropriate disposition of the player must be determined by the treating healthcare provider in a timely manner. If no healthcare provider is available, the player should be safely removed from practice or play and urgent referral to a physician arranged.

H. Once the first aid issues are addressed, an assessment of the concussive injury should be made using the SCAT3 or other sideline assessment tools.

I. The player should not be left alone following the injury and serial monitoring for deterioration is essential over the initial few hours following injury.

J. A player with diagnosed concussion should not be allowed to RTP on the day of injury.

284. U.S. Soccer does not require or enforce a rule requiring that a player be evaluated by a physician on the sideline and before returning to play.

285. Further, U.S. Soccer does not require that a physician or other licensed healthcare provider administer a sideline test/evaluation.

286. U.S. Soccer's failure to implement a policy requiring administration of a standardized sideline evaluation tool such as the SCAT3 to evaluate all players is in contravention of best practices, including the Zurich II Protocol, which requires that a "player should be evaluated by a physician or other licensed healthcare provider onsite...."

¹²⁷ *Id.* at 3.

287. U.S. Soccer's failure to require physician involvement and that players with concussion symptoms be seen and cleared by medical personnel who are experienced in concussion is in contravention of best practices.

288. Because U.S. Soccer follows FIFA's "Laws of the Game," it knew that its failure to adopt best practices for concussion management would have the effect of the organizations that follow FIFA Rules not considering best concussion management practices to be part of the Laws of the Game.

6. USAYSA.

a. USAYSA Has Knowledge of Consensus Best Practices.

289. In 2011, the USAYSA partnered with the Center for Disease Control's ("CDC") "Heads Up" Concussion program and adopted its "Concussion Procedure and Protocol" ("USAYSA Protocol") for its largest tournament, the US Youth Soccer National Championship Series. The USAYSA Protocol requires players suspected of having a concussion to sit out of play for at least 24 hours and only allows a player to return to play after release from a licensed medical doctor specializing in concussion treatment and management.¹²⁸

290. The USAYSA Protocol, adopted solely for the US Youth Soccer National Championship Series tournament, involves 5 steps: (i) determining whether a concussion occurred; (ii) determining whether emergency treatment is needed; (iii) focusing on various areas (including balance, movement, speech, memory, attention, confusion, state of consciousness, mood, headaches, nausea or vomiting, and sensitivity to light) every 5-10 minutes for 1-2 hours; (iv) requiring a player diagnosed with a possible concussion to return to play only after release from a medical doctor specializing in concussion treatment and management; and (v) filling out a concussion notice form and notifying the player's parents or guardian.¹²⁹

¹²⁸ http://www.usyouthsoccer.org/news/hey_doc_when_can_i_return_to_play/ (last visited Aug. 7, 2014).

¹²⁹ <https://www.usyouthsoccer.org/FileDownload.aspx?D=cwkZAqxQGFyc3yDn1Cbhu9xeqtA0p8tppc0YS2xtkM0=> (last visited Aug. 7, 2014).

b. USAYSA Fails to Adopt *Any* Consensus Guidelines Promulgated by the International Conferences on Concussion in Sport.

291. Despite knowledge of consensus best practices as evidenced by the USAYSA Protocol, the USAYSA has not adopted its own Protocol for any members or tournaments other than the US Youth National Championship Series tournament. Moreover, USAYSA has not adopted any of the internationally accepted guidelines set forth in the Vienna, Prague, Zurich I, or Zurich II Protocols organization-wide, including, but not limited to: (i) specific return to play guidelines; (ii) a prohibition on returning to play in the same game after sustaining a concussion; and (iii) providing education of athletes, colleagues, those working with athletes, and the general public.

292. Notably, USAYSA's Official Policy on Players and Playing Rules as of September 1, 2013, do not mention concussions, concussion protocols, or concussion-related playing rules.¹³⁰

293. Rather, USAYSA's website merely provides links to informational materials.¹³¹ There is no evidence that USAYSA implements or enforces any consensus best practice guidelines or rules aside from its limited "Concussion Procedure and Protocol," adopted solely for the US Youth Soccer National Championship Series tournament.

294. Accordingly, USAYSA's failure to require or implement *any* consensus best practices, including best practice guidelines relating to concussion management of child and adolescent individuals, despite the fact that the organization is designed for players aged 5-19, is a clear breach of its duty and commitment to provide a "fun, safe and healthy game for ALL kids..."¹³²

c. USAYSA's Concussion Protocol For Its Largest Tournament, the US Youth Soccer National Championship Series, Still Fails to Adopt the Consensus Guidelines.

295. In comparison to the most recent Zurich II Protocol, USAYSA's current "Concussion Procedure and Protocol," which is only in effect at the US Youth Soccer National Championship Series tournament, remains deficient especially in light of the Zurich II Protocol's specific

¹³⁰<https://www.usyouthsoccer.org/FileDownload.aspx?D=AOnDpCrCujC0NERGGnFmx9nONaL4T7rXjGS5PHWM8AE=> (last visited Aug. 21, 2014).

¹³¹http://www.usyouthsoccer.org/news/hey_doc_when_can_i_return_to_play/ (last visited Aug. 21, 2014).

¹³² *Id.*

1 recommendations and requirements for concussion management in youth and adolescents – which
2 comprise the majority of USAYSA’s player pool.

3 296. Specifically, the USAYSA has failed to implement the following best practices of
4 concussion management as established by the International Conferences on Concussion in Sport:

- 5 • A mandatory 24-hour stepwise return to play guideline which
6 accounts for the fact that a day is needed between return to play
7 steps and that typically a week of asymptomatic time is needed
8 to resolve symptoms relating to a concussion prior to return to
9 play;
- 10 • Formal baseline testing regardless of the age or level of
11 performance of the players and neuropsychological testing to
12 evaluate injury;
- 13 • Require that a player with a concussion or a suspected
14 concussion be evaluated and managed on-site by medical
15 personnel with specific expertise in concussion diagnosis,
16 treatment, and management;
- 17 • Require a different concussion symptom checklist for children
18 below the age of 13;
- 19 • Require that treatment and evaluation involve parental input;
- 20 • Require utilization of the SCAT3 sideline concussion
21 assessment tool specifically designed for children aged 5-12;
- 22 • Require that a child should not return to play before the child
23 has returned to school successfully;
- 24 • Require a more conservative return to play approach for
25 children.

26 **7. USAYSA Fails to Require a Stepwise Return to Play Protocol.**

27 297. USAYSA has failed to implement consensus guidelines regarding return to play
28 protocol as set forth in the Zurich II Protocol. The Zurich II Protocol recommended specific return to
play stepwise process as follows:¹³³

[Return to play protocol] following a concussion follows a stepwise
process ... With this stepwise progression, the athlete should continue
to proceed to the next level if asymptomatic at the current level.

¹³³ Zurich II Protocol, at 3.

Generally, each step should take 24 h so that an athlete would take approximately one week to proceed through the full rehabilitation protocol once they are asymptomatic at rest and with provocative exercise. If any postconcussion symptoms occur while in the stepwise programme, then the patient should drop back to the previous asymptomatic level and try to progress again after a further 24 h period of rest has passed.

298. Zurich II included the following chart:¹³⁴

Graduated Return-to-Play Protocol:

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
1. No activity	Symptom limited physical and cognitive rest	Recovery
2. Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum permitted heart rate No resistance training	Increase HR
3. Sport-specific exercise	Skating drills in ice hockey, running drills in soccer. No head impact activities	Add movement
4. Non-contact training drills	Progression to more complex training drills, eg, passing drills in football and ice hockey May start progressive resistance training	Exercise, coordination and cognitive load
5. Full-contact practice	Following medical clearance participate in normal training activities	Restore confidence and assess functional skills by coaching staff
6. Return to play	Normal game play	

299. Zurich II explained that a single return to play paradigm should be used for all athletes and that formal neuropsychological testing should be used in high-risk sports regardless of age or level of competition, explaining:¹³⁵

All athletes regardless of level of participation should be managed using the same treatment and return to play paradigm. The available resources and expertise in concussion evaluation are of more importance in determining management than a separation between elite and non-elite athlete management. Although formal NP testing may be

¹³⁴ *Id.* at 4.

¹³⁵ *Id.* at 5.

beyond the resources of many sports of individuals, it is recommended that, in all organised high-risk sports, consideration be given to having this cognitive evaluation, regardless of the age or level of performance.

300. The USAYSA “Concussion Procedure and Protocol” does not require or even mention a graded stepwise return to play protocol. Similarly, the protocol does not require or explain that a day is needed between return to play steps, that typically a week of asymptomatic time is needed to resolve symptoms prior to returning to play and that “it is appropriate to extend the amount of time of asymptomatic rest and/or the length of the graded exertion in children and adolescents.”¹³⁶

301. USAYSA’s failure to require or adopt a stepwise return to play protocol is in contravention of consensus best practices.

8. USAYSA Fails to Require Formal Baseline and/or Post-Injury Neurocognitive Testing of Players.

302. The International Consensus Statements provide that neuropsychological testing is one of the “cornerstones” of appropriate concussion management and contributes significantly to both understanding the injury and management of the individual.

303. The importance of neuropsychological testing has been reinforced with each subsequent International Consensus Statement. For example, the Zurich II Protocol recommends that “all athletes should have a clinical neurological assessment (including assessment of their cognitive function) as part of their overall management,” and that all high-risk sports, regardless of the age or level of performance, have formal baseline neuropsychological screening.¹³⁷

304. The USAYSA “Concussion Procedure and Protocol” fails to mention, much less require, formal baseline testing or the use of neuropsychological testing to assess injury. Further, the USAYSA “Concussion Procedure and Protocol” fails to mention that, in the absence of neuropsychological testing, a more conservative return to play approach may be appropriate.

305. USAYSA’s failure to require formal baseline testing and to utilize neuropsychological testing is in contravention of consensus best practices. Without a formal baseline, it is very difficult

¹³⁶ *Id.* at 5-6.

¹³⁷ *Id.*

1 for a physician to determine when a patient has recovered. And returning a player to play before they
2 are fully recovered negligently puts them at risk for permanent brain injury.

3 **9. USAYSA Fails to Require that Players' Concussions Be Managed**
4 **by Medical Personnel with Specific Expertise in Concussion**
5 **Diagnosis, Treatment, and Management.**

6 306. The Zurich II Protocol provides the following in regards to medical evaluation of
7 when a player shows any feature of a concussion:¹³⁸

8 **On-field or sideline evaluation of acute concussion**

9 When a player shows ANY features of a concussion:

- 10 A. The player should be evaluated by a physician or other licensed
11 healthcare provider onsite using standard emergency
12 management principles and particular attention should be given
13 to excluding a cervical spine injury.
- 14 B. The appropriate disposition of the player must be determined
15 by the treating healthcare provider in a timely manner. If no
16 healthcare provider is available, the player should be safely
17 removed from practice or play and urgent referral to a
18 physician arranged.
- 19 C. Once the first aid issues are addressed, an assessment of the
20 concussive injury should be made using the SCAT3 or other
21 sideline assessment tools.
- 22 D. The player should not be left alone following the injury and
23 serial monitoring for deterioration is essential over the initial
24 few hours following injury.
- 25 E. A player with diagnosed concussion should not be allowed to
26 RTP on the day of injury.

27 307. The USAYSA "Concussion Procedure and Protocol" does not require that an athletic
28 trainer or physician evaluate or monitor an athlete on site with a suspected concussion.

308. Instead, the USAYSA protocol simply requires that if a possible concussion is
suspected, a treating individual should focus on and monitor certain symptoms for 1-2 hours, but it is
unclear who is responsible for this task. Regardless, it certainly does not require an athletic trainer or

¹³⁸ *Id.* at 3.

1 physician to monitor or evaluate the athlete onsite, or in the alternative require that an individual
2 refer the athlete to a physician in contravention of consensus best practices.

3 309. Instead of requiring immediate physician involvement, USAYSA only requires that a
4 “notification form” be given to parents after a concussion which tells parents to “take the necessary
5 precautions and seek a professional medical opinion before allowing your daughter or son to
6 participate further.”¹³⁹

7 310. USAYSA’s failure to require immediate physician involvement or require that a
8 player with concussion symptoms be monitored and evaluated onsite is in contravention of best
9 practices.

10 **10. USAYSA Fails to Adopt Consensus Best Practices for**
11 **Management of Children and Adolescents with Concussion.**

12 311. USAYSA has also failed to adopt best practice guidelines relating to concussion
13 management of child and adolescent individuals despite the fact that the organization is designed for
14 players aged 5-19.

15 312. For example, the Zurich II Protocol states that “the evaluation and management
16 recommendations herein can be applied to children and adolescents down to the age of 13 years ...
17 below that age, children report concussion symptoms different from adults and would require age-
18 appropriate symptom checklists as a component of assessment.”¹⁴⁰

19 313. Accordingly, the Zurich II Protocol recommends the usage and implementation of a
20 specially designed SCAT3 sideline concussion assessment tool for individuals aged 5-12.¹⁴¹

21 314. While the USAYSA “Concussion Procedure and Protocol” provides a list of
22 symptoms to aid an individual in determining whether a concussion occurred, the USAYSA’s failure
23 to account for and require an age-appropriate symptom checklist is in contravention of best practices.

24 315. The Zurich II Protocol also states:¹⁴²

25 ¹³⁹ <https://www.usyouthsoccer.org/FileDownload.aspx?D=cwkZAqxQGFyc3yDn1Cbhu9xeqtA0p8tpc0YS2xtkM0=> (last visited Aug. 7, 2014).

26 ¹⁴⁰ Zurich II Protocol, at 5.

27 ¹⁴¹ *Id.*

28 ¹⁴² *Id.* at 5-6.

1 It was agreed by the panel that no return to sport or activity should
 2 occur before the child/adolescent athlete has managed to return to
 3 school successfully. In addition, the concept of ‘cognitive rest’ was
 4 highlighted with special reference to a child’s need to limit exertion
 5 with activities of daily living that may exacerbate symptoms. School
 6 attendance and activities may also need to be modified to avoid
 7 provocation of symptoms. Children should not be returned to sport
 8 until clinically completely symptom-free, which may require a longer
 9 time frame than for adults.

10 316. While the USAYSA “Concussion Procedure and Protocol” requires that a player’s
 11 parents be notified, the notification form does not: (i) indicate that a child should not return to play
 12 before the child has returned to school successfully; (ii) indicate that a more conservative return to
 13 play approach for children is necessary; or (iii) indicate that parental involvement in the treatment
 14 and evaluation of the child is necessary.

15 317. USAYSA’s failure to implement or require these consensus best practices for
 16 concussion management of children and adolescents is in contravention of best practices.

17 7. AYSO.

18 a. Prior to 2009, AYSO Failed to Adopt Any Consensus Guidelines 19 Promulgated by the International Conferences on Concussion in Sport.

20 318. As of 2009, AYSO had not adopted any of the internationally accepted guidelines set
 21 forth in the Vienna, Prague, Zurich I, or Zurich II Protocols including, but not limited to: (i) specific
 22 return to play guidelines; (ii) a prohibition on returning to play in the same game after sustaining a
 23 concussion; and (iii) providing education of athletes, colleagues, those working with athletes, and the
 24 general public.

25 319. In 2009, AYSO implemented a “national policy statement” regarding concussion
 26 awareness and safety which required the following components: (i) broad dissemination of
 27 information regarding signs or symptoms throughout AYSO; (ii) recommending concussion
 28 awareness training for all coaches, referees, executive committee members, advisory committee
 members, section/area/region boards and staff; and (iii) requiring concussion awareness training for

all coaches and other “officials” as required by states with concussion laws applicable to AYSO programs.¹⁴³

320. AYSO also partnered with the CDC to create a “Heads Up Concussion Action Plan” which requires coaches to implement a four-step process once an athlete has a concussion:¹⁴⁴

COACH ACTION PLAN

If you suspect that an athlete has a concussion, you should take the following four steps:

1. Remove the athlete from play.
2. Ensure that the athlete is evaluated by a health care professional experienced in evaluating for concussion. Do not try to judge the seriousness of the injury yourself.
3. Inform the athlete’s parents or guardians about the possible concussion and give them the CDC fact sheet for parents on concussion.
4. Keep the athlete out of play the day of the injury and until a health care professional, experienced in evaluating for concussion, says they are symptom-free and it’s OK to return to play.

ADDITIONAL AYSO COACH PROCEDURES

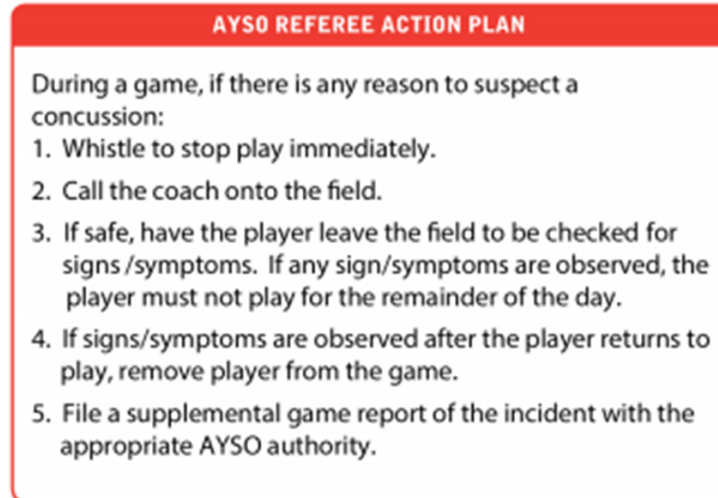
5. Submit AYSO Incident Report to Safety Director
6. Refer parents to the AYSO/CDC Information sheet and SAI information available at AYSO.org
7. Obtain signed AYSO Participation Release from Parent/Guardian prior to return to play
8. Obtain a Medical Release if required by State Law
9. Give all signed forms to your AYSO Safety Director

321. The “Heads Up Concussion Action Plan” also requires referees to take the following steps following a suspected concussion:¹⁴⁵

¹⁴³ http://www.ayso.org/Assets/libraries/resources/policy_statements.pdf (last visited Aug. 7, 2014); *see also* <http://aysoareal.com/ayso-concussion-policy-and-training/> (last visited Aug. 7, 2014).

¹⁴⁴ http://www.ayso.org/Assets/For+Volunteers/Coaches/Forms+26+Documents/AYSO_CDC_ConcussionActionPlan.pdf.

¹⁴⁵ *Id.*



b. AYSO's Concussion Protocol Still Fails to Adopt the Consensus Guidelines.

322. AYSO's current "Concussion Action Plan" remains deficient especially in light of the Zurich II Protocol's specific recommendations and requirements for concussion management in youth and adolescents – which comprise the majority of AYSO's player pool.

323. Specifically, the AYSO has failed to implement the following best practices of concussion management as established by the International Conferences on Concussion in Sport:

- A mandatory 24 hour stepwise return to play guideline which accounts for the fact that a day is needed between return to play steps and that typically a week of asymptomatic time is needed to resolve symptoms relating to a concussion prior to return to play;
- Formal baseline testing regardless of the age or level of performance of the players and neuropsychological testing to evaluate injury;
- Require that a player with a concussion or a suspected concussion be evaluated and managed on-site by medical personnel with specific expertise in concussion diagnosis, treatment, and management;
- Require a different concussion symptom checklist for children below the age of 13;
- Require that treatment and evaluation involve parental input;

- Require utilization of the SCAT3 sideline concussion assessment tool specifically designed for children aged 5-12; and
- Require that a child should not return to play before the child has returned to school successfully.

11. AYSO Fails to Require a Stepwise Return to Play Protocol.

324. AYSO has failed to implement or require the consensus guidelines regarding return to play protocol as set forth in the Vienna Protocol – and updated with the Prague, Zurich, and Zurich II Protocols. The Zurich II Protocol recommended specific return to play stepwise process as follows:¹⁴⁶

[Return to play protocol] following a concussion follows a stepwise process ... With this stepwise progression, the athlete should continue to proceed to the next level if asymptomatic at the current level. Generally, each step should take 24 h so that an athlete would take approximately one week to proceed through the full rehabilitation protocol once they are asymptomatic at rest and with provocative exercise. If any postconcussion symptoms occur while in the stepwise programme, then the patient should drop back to the previous asymptomatic level and try to progress again after a further 24 h period of rest has passed.

325. Zurich II included the following chart:¹⁴⁷

Graduated Return-to-Play Protocol:

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
1. No activity	Symptom limited physical and cognitive rest	Recovery
2. Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum permitted heart rate No resistance training	Increase HR
3. Sport-specific exercise	Skating drills in ice hockey, running drills in soccer. No head impact activities	Add movement
4. Non-contact training drills	Progression to more complex training drills, eg, passing drills in	Exercise, coordination and cognitive load

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* at 4.

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
	football and ice hockey May start progressive resistance training	
5. Full-contact practice	Following medical clearance participate in normal training activities	Restore confidence and assess functional skills by coaching staff
6. Return to play	Normal game play	

326. Zurich II explained that a single return to play paradigm should be used for all athletes and that formal neuropsychological testing should be used in high-risk sports regardless of age or level of competition, explaining:¹⁴⁸

All athletes regardless of level of participation should be managed using the same treatment and return to play paradigm. The available resources and expertise in concussion evaluation are of more importance in determining management than a separation between elite and non-elite athlete management. Although formal NP testing may be beyond the resources of many sports of individuals, it is recommended that, in all organised high-risk sports, consideration be given to having this cognitive evaluation, regardless of the age or level of performance.

327. The AYSO Action Plan simply does not require or provide a graded stepwise return to play protocol. Similarly, the Action Plan does not require or explain that a day is needed between return to play steps, that typically a week of asymptomatic time is needed to resolve symptoms prior to returning to play and that “it is appropriate to extend the amount of time of asymptomatic rest and/or the length of the graded exertion in children and adolescents.”¹⁴⁹

328. AYSO’s failure to require or adopt a graded stepwise return to play protocol is in contravention of consensus best practices.

12. AYSO Fails to Require Formal Baseline and/or Post-Injury Neurocognitive Testing of Players.

329. The International Consensus Statements provide that neuropsychological testing is one of the “cornerstones” of appropriate concussion management and contributes significantly to both understanding the injury and management of the individual.

¹⁴⁸ *Id.* at 5.

¹⁴⁹ *Id.*

330. The importance of neuropsychological testing has been reinforced with each subsequent International Consensus Statement. For example, the Zurich II Protocol recommends that “all athletes should have a clinical neurological assessment (including assessment of their cognitive function) as part of their overall management,” and that all high-risk sports, regardless of the age or level of performance, have formal baseline neuropsychological screening.¹⁵⁰

331. The AYSO Action Plan fails to mention, much less require, formal baseline testing or the use of neuropsychological testing to assess injury. Further, the AYSO Action Plan fails to mention that in the absence of neuropsychological testing, a more conservative return to play approach may be appropriate.

332. AYSO’s failure to require formal baseline testing is in contravention of consensus best practices. Without a formal baseline, it is very difficult for a physician to determine when a patient has recovered. And returning a player to play before they are fully recovered negligently puts them at risk for permanent brain injury.

13. AYSO Fails to Require that Players’ Concussions Be Managed and Cleared by Medical Personnel with Specific Expertise in Concussion Diagnosis, Treatment, and Management.

333. The Zurich II Protocol provides the following in regards to medical evaluation of when a player shows any feature of a concussion:¹⁵¹

On-field or sideline evaluation of acute concussion

When a player shows ANY features of a concussion:

- A. The player should be evaluated by a physician or other licensed healthcare provider onsite using standard emergency management principles and particular attention should be given to excluding a cervical spine injury.
- B. The appropriate disposition of the player must be determined by the treating healthcare provider in a timely manner. If no healthcare provider is available, the player should be safely removed from practice or play and urgent referral to a physician arranged.

¹⁵⁰ *Id.* at 3.

¹⁵¹ *Id.* at 2.

- 1 C. Once the first aid issues are addressed, an assessment of the
2 concussive injury should be made using the SCAT3 or other
3 sideline assessment tools.
- 4 D. The player should not be left alone following the injury and
5 serial monitoring for deterioration is essential over the initial
6 few hours following injury.
- 7 E. A player with diagnosed concussion should not be allowed to
8 RTP on the day of injury.

9 334. The AYSO Action Plan does not require that an athletic trainer or physician monitor
10 or evaluate an athlete onsite with a suspected concussion. While the AYSO Action Plan requires that
11 a coach “ensure that the athlete is evaluated by a health care professional experienced in evaluating
12 for concussion,” this evaluation does not occur onsite as required by the Zurich II Protocol which
13 states that “the player should be evaluated by a physician or other licensed healthcare provider
14 *onsite....*”¹⁵²

15 335. Further, the AYSO Action Plan only requires a coach to provide a parent or guardian
16 with a “Parent/Athlete Concussion Information Sheet” which contains “concussion danger signs”
17 and tells a parent to “seek medical attention.”¹⁵³ AYSO only requires that a “notification form” be
18 given to parents after a concussion which advises parents to “take the necessary precautions and seek
19 a professional medical opinion before allowing your daughter or son to participate further.”¹⁵⁴

20 336. AYSO’s failure to require that a player be evaluated and monitored by an athletic
21 trainer or physician onsite following a concussion is in contravention of consensus best practices.

22 **14. AYSO Fails to Adopt Consensus Best Practices for Management of** 23 **Children and Adolescents with Concussion.**

24 337. AYSO has also failed to adopt best practices relating to concussion management of
25 child and adolescent individuals despite the fact that the organization only has players aged 5-19.

26 338. For example, the Zurich II Protocol states that “the evaluation and management
27 recommendations herein can be applied to children and adolescents down to the age of 13 years ...
28

¹⁵² *Id.* (emphasis added).

¹⁵³ <http://www.ayso.org/Assets/libraries/resources/AYSOCDCConcussionHandout.pdf> (last visited Aug. 7, 2014).

¹⁵⁴ *Id.*

below that age, children report concussion symptoms different from adults and would require age-appropriate symptom checklists as a component of assessment.”¹⁵⁵

339. Accordingly, the Zurich II Protocol recommends the usage and implementation of a specially designed SCAT3 sideline concussion assessment tool for individuals aged 5-12.¹⁵⁶

340. While the AYSO Action Plan provides a list of symptoms to aid in determining whether a concussion occurred, the AYSO’s failure to account for symptoms specific to children is against best practices.

341. The Zurich II Protocol also states¹⁵⁷:

It was agreed by the panel that no return to sport or activity should occur before the child/adolescent athlete has managed to return to school successfully. In addition, the concept of ‘cognitive rest’ was highlighted with special reference to a child’s need to limit exertion with activities of daily living that may exacerbate symptoms. School attendance and activities may also need to be modified to avoid provocation of symptoms. Children should not be returned to sport until clinically completely symptom-free, which may require a longer time frame than for adults.

342. While the AYSO Action Plan requires that players’ parents be notified, the notification form does not indicate or require that a child should not return to play before the child has returned to school successfully or parental involvement in the treatment and evaluation of the child.

343. AYSO’s failure to implement or require these consensus best practices for concussion management of children and adolescents is in contravention of best practices.

8. US Club Soccer.

a. US Club Soccer Has Failed to Adopt Any Consensus Guidelines Promulgated by the International Conferences on Concussion in Sport.

344. US Club Soccer has neither endorsed nor adopted any of the internationally accepted guidelines set forth in the Vienna, Prague, Zurich I or Zurich II Protocols including, but not limited to: (i) specific return to play guidelines; (ii) a prohibition on returning to play in the same game after

¹⁵⁵ Zurich II Protocol, at 5.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

1 sustaining a concussion; and (iii) providing education of athletes, those working with athletes, and
2 the general public.

3 345. Notably, US Club Soccer's Official Policies as of November 5, 2012, do not mention
4 concussions, concussion protocols, or concussion-related playing rules.¹⁵⁸

5 346. Rather, US Club Soccer's website merely references a link to U.S. Soccer's
6 concussion guidelines¹⁵⁹ and provides links to informational materials. There is no evidence that US
7 Club Soccer implements or enforces U.S. Soccer's concussion guidelines which U.S. Soccer
8 describes as providing "state of the art education, evaluation and management *among national team*
9 *players*" which includes "pre-injury baseline testing with comprehensive post-injury follow-up
10 evaluations and return to play protocols."¹⁶⁰

11 347. US Club Soccer provides a "CDC- Soccer Clipboard Sticker" which states an action
12 plan requiring removal of an athlete from play after a concussion, ensuring that the athlete is
13 evaluated by a health care professional, informing the athlete's parents or guardians, and keeping the
14 athlete out of play the day of the injury until they get medical clearance.¹⁶¹ However, US Club
15 Soccer does not require any of these steps in its rules, articulate these steps in an official policy, or
16 enforce these steps.

17 348. Accordingly, US Club Soccer's failure to require, implement, or enforce *any*
18 consensus best practices is a clear breach of its duty and commitment to provide "a safe environment
19 for its Members and participants."¹⁶²
20
21

22 ¹⁵⁸ <http://www.usclubsoccer.org/wp-content/uploads/2014/01/US-CLUB-SOCCER-POLICIES-Complete-Documnt-2012-11-05.pdf> (last visited Aug. 7, 2014).
23

24 ¹⁵⁹ <http://www.usclubsoccer.org/members-area/bylaws-policies-guidelines/> (last visited Aug. 7, 2014).
25

26 ¹⁶⁰ <http://www.ussoccer.com/about/federation-services/sports-medicine.aspx> (last visited Aug. 7, 2014) (emphasis added).
27

28 ¹⁶¹ http://www.cdc.gov/concussion/HeadsUp/pdf/Soccer_Clipboard_Sticker.pdf (last visited Aug. 7, 2014).
29

¹⁶² <http://www.usclubsoccer.org/wp-content/uploads/2014/01/US-CLUB-SOCCER-POLICIES-Complete-Documnt-2012-11-05.pdf>, p. 17 (last visited Aug. 7, 2014).
30

1 **9. CYSA North**

2 **a. Prior to 2013, CYSA North Failed to Adopt Any Consensus Guidelines**
 3 **Promulgated by the International Conferences on Concussion in Sport.**

4 349. As of 2013, CYSA North had not adopted any of the internationally accepted
 5 guidelines has not adopted any of the internationally accepted guidelines set forth in the Vienna,
 6 Prague, Zurich I, or Zurich II Protocols including, but not limited to: (i) specific return to play
 7 guidelines including a specific graded stepwise return to play protocol indicating that a day is needed
 8 between return to play steps that typically a week of asymptomatic time is needed to resolve
 9 symptoms prior to returning to play and that “it is appropriate to extend the amount of time of
 10 asymptomatic rest and/or the length of the graded exertion in children and adolescents”¹⁶³; (ii) a
 11 prohibition on returning to play in the same game after sustaining a concussion; (iii) requiring formal
 12 baseline and/or post-injury neurocognitive testing of players; (iv) requiring that players’ concussions
 13 be managed and cleared by physicians by medical personnel with specific expertise in concussion
 14 management, diagnosis and treatment; (v) adopting consensus best practices for management of
 15 children and adolescents with concussions; and (vi) providing concussion education to athletes, those
 16 working with athletes, and the general public.

17 350. On or about September 30, 2013,¹⁶⁴ CYSA North implemented a “Concussion
 18 Procedure and Protocol For Cal North Soccer Events” (“CYSA North Protocol”).¹⁶⁵ The CYSA
 19 North Protocol requires players suspected of having a concussion to sit out of play for at least 24
 20 hours and only allows a player to return to play after release from a licensed medical doctor
 21 specializing in concussion treatment and management.¹⁶⁶

22 351. The CYSA North Protocol, which is an almost verbatim a replica of the USAYSA
 23 Protocol, involves 5 steps: (i) determining whether a concussion occurred; (ii) determining whether

24 ¹⁶³ Zurich II Protocol at 5.

25 ¹⁶⁴ <http://www.calnorth.org/extranet/?DocumentId=T2SxiCJP5UvPwcMULE5WpCFIY05nHtk/Y3mo0dzpQTM=> (last visited August 25, 2014). (last visited Aug. 25, 2014) (indicating that the Cal
 26 North Concussion Procedure and Protocol was posted on approximately September 30, 2013).

27 ¹⁶⁵ <http://www.calnorth.org/FileDownload.aspx?D=T2SxiCJP5UvPwcMULE5WpCFIY05nHtk/Y3mo0dzpQTM=> (last visited Aug. 25, 2014).

28 ¹⁶⁶ *Id.* (Steps 3 and 4).

1 emergency treatment is needed; (iii) focusing on various areas (including balance, movement,
 2 speech, memory, attention, confusion, state of consciousness, mood, headaches, nausea or vomiting,
 3 and sensitivity to light) every 5-10 minutes for 1-2 hours; (iv) requiring a player diagnosed with a
 4 possible concussion to return to play only after release from a medical doctor specializing in
 5 concussion treatment and management; and (v) if there is a possibility of concussion, filling out a
 6 concussion notice form to be signed by a team official, notifying the player's parents or guardian,
 7 and surrendering the player pass to the league representative.¹⁶⁷

8 **b. CYSA North's Concussion Protocol Still Fails to Adopt the Consensus**
 9 **Guidelines.**

10 352. In comparison to the most recent Zurich II Protocol, the CYSA North Protocol
 11 remains deficient especially in light of the Zurich II Protocol's specific recommendations and
 12 requirements for concussion management in youth and adolescents – which comprise the majority of
 13 CYSA North' player pool.

14 353. Specifically, CYSA North has failed to implement the following best practices of
 15 concussion management as established by the International Conferences on Concussion in Sport:

- 16 • A mandatory 24-hour stepwise return to play guideline which
 17 accounts for the fact that a day is needed between return to play
 18 steps and that typically a week of asymptomatic time is needed
 19 to resolve symptoms relating to a concussion prior to return to
 20 play;
- 21 • Formal baseline testing regardless of the age or level of
 22 performance of the players and neuropsychological testing to
 23 evaluate injury;
- 24 • Require that a player with a concussion or a suspected
 25 concussion be evaluated and managed on-site by medical
 26 personnel with specific expertise in concussion diagnosis,
 27 treatment, and management;
- 28 • Require a different concussion symptom checklist for children
 below the age of 13;
- Require that treatment and evaluation involve parental input;

¹⁶⁷ <https://www.usyouthsoccer.org/FileDownload.aspx?D=cwkZAqxQGFyc3yDn1Cbhu9xeqtA0p8tppc0YS2xtkM0=> (last visited Aug. 7, 2014).

- Require utilization of the SCAT3 sideline concussion assessment tool specifically designed for children aged 5-12;
- Require that a child should not return to play before the child has returned to school successfully;
- Require a more conservative return to play approach for children.

(1) **CYSA North Fails to Require a Stepwise Return to Play Protocol.**

354. CYSA North has failed to implement consensus guidelines regarding return to play protocol as set forth in the Zurich II Protocol. The Zurich II Protocol recommended specific return to play stepwise process as follows:¹⁶⁸

Return to play protocol following a concussion follows a stepwise process ... With this stepwise progression, the athlete should continue to proceed to the next level if asymptomatic at the current level. Generally, each step should take 24 h so that an athlete would take approximately one week to proceed through the full rehabilitation protocol once they are asymptomatic at rest and with provocative exercise. If any postconcussion symptoms occur while in the stepwise programme, then the patient should drop back to the previous asymptomatic level and try to progress again after a further 24 h period of rest has passed.

355. Zurich II included the following chart:¹⁶⁹

Graduated Return-to-Play Protocol:

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
1. No activity	Symptom limited physical and cognitive rest	Recovery
2. Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum permitted heart rate No resistance training	Increase HR
3. Sport-specific exercise	Skating drills in ice hockey, running drills in soccer. No head impact activities	Add movement

¹⁶⁸ *Id.*

¹⁶⁹ *Id.* at 4.

Rehabilitation stage	Functional exercise at each stage of rehabilitation	Objective of each stage
4. Non-contact training drills	Progression to more complex training drills, eg, passing drills in football and ice hockey May start progressive resistance training	Exercise, coordination and cognitive load
5. Full-contact practice	Following medical clearance participate in normal training activities	Restore confidence and assess functional skills by coaching staff
6. Return to play	Normal game play	

356. Zurich II explained that a single return to play paradigm should be used for all athletes and that formal neuropsychological testing should be used in high-risk sports regardless of age or level of competition, explaining:¹⁷⁰

All athletes regardless of level of participation should be managed using the same treatment and return to play paradigm. The available resources and expertise in concussion evaluation are of more importance in determining management than a separation between elite and non-elite athlete management. Although formal NP testing may be beyond the resources of many sports of individuals, it is recommended that, in all organised high-risk sports, consideration be given to having this cognitive evaluation, regardless of the age or level of performance.

357. The CYSA North Protocol does not require or even mention a graded stepwise return to play protocol. Similarly, the protocol does not require or explain that a day is needed between return to play steps, that typically a week of asymptomatic time is needed to resolve symptoms prior to returning to play and that “it is appropriate to extend the amount of time of asymptomatic rest and/or the length of the graded exertion in children and adolescents.”¹⁷¹

358. CYSA North’s failure to require or adopt a stepwise return to play protocol is in contravention of consensus best practices.

¹⁷⁰ *Id.* at 5.

¹⁷¹ Zurich II Protocol, at 5-6.

(2) **CYSA North Fails to Require Formal Baseline and/or Post-Injury Neurocognitive Testing of Players.**

359. The International Consensus Statements provide that neuropsychological testing is one of the “cornerstones” of appropriate concussion management and contributes significantly to both understanding the injury and management of the individual.

360. The importance of neuropsychological testing has been reinforced with each subsequent International Consensus Statement. For example, the Zurich II Protocol recommends that “all athletes should have a clinical neurological assessment (including assessment of their cognitive function) as part of their overall management,” and that all high-risk sports, regardless of the age or level of performance, have formal baseline neuropsychological screening.¹⁷²

361. The CYSA North Protocol fails to mention, much less require, formal baseline testing or the use of neuropsychological testing to assess injury. Further, the CYSA North Protocol fails to mention that, in the absence of neuropsychological testing, a more conservative return to play approach may be appropriate.

362. CYSA North’s failure to require formal baseline testing and to utilize neuropsychological testing is in contravention of consensus best practices. Without a formal baseline, it is very difficult for a physician to determine when a patient has recovered. And returning a player to play before they are fully recovered negligently puts them at risk for permanent brain injury.

(3) **CYSA North Fails to Require that Players’ Concussions Be Managed by Medical Personnel with Specific Expertise in Concussion Diagnosis, Treatment, and Management.**

363. The Zurich II Protocol provides the following in regards to medical evaluation of when a player shows any feature of a concussion:¹⁷³

On-field or sideline evaluation of acute concussion

When a player shows ANY features of a concussion:

¹⁷² P. McCrory et al., *Consensus statement on concussion in sport: the 4th International Conference on Concussion in Sport held in Zurich, November 2012*, 47 BRIT. J. SPORTS MED. 250 (2013), available at <http://bjsm.bmj.com/content/47/5/250.full.pdf+html>.

¹⁷³ Zurich II Protocol at 3.

- A. The player should be evaluated by a physician or other licensed healthcare provider onsite using standard emergency management principles and particular attention should be given to excluding a cervical spine injury.
- B. The appropriate disposition of the player must be determined by the treating healthcare provider in a timely manner. If no healthcare provider is available, the player should be safely removed from practice or play and urgent referral to a physician arranged.
- C. Once the first aid issues are addressed, an assessment of the concussive injury should be made using the SCAT3 or other sideline assessment tools.
- D. The player should not be left alone following the injury and serial monitoring for deterioration is essential over the initial few hours following injury.
- E. A player with diagnosed concussion should not be allowed to RTP on the day of injury.

364. The CYSA North Protocol does not require that an athletic trainer or physician evaluate or monitor an athlete on site with a suspected concussion.

365. Instead, the CYSA North Protocol simply requires that if a possible concussion is suspected, a treating individual should focus on and monitor certain symptoms for 1-2 hours but it is unclear who is responsible for this task. Regardless, it certainly does not require an athletic trainer or physician to monitor or evaluate the athlete onsite, or in the alternative require that an individual refer the athlete to a physician in contravention of consensus best practices.

366. Instead of requiring immediate physician involvement, CYSA North only requires that a “notification form” be given to parents after a concussion which tells parents to “take the necessary precautions and seek a professional medical opinion before allowing your daughter or son to participate further.”¹⁷⁴

367. CYSA North’s failure to require immediate physician involvement or require that a player with concussion symptoms be monitored and evaluated onsite by medical personnel who is experienced in concussion is in contravention of best practices.

¹⁷⁴<http://www.calnorth.org/FileDownload.aspx?D=v/8alO2dI8gRtUnsYVf1fqF9qPyarIxxv9maqFz47dEE=> (last visited Aug. 25, 2014).

(4) **CYSA North Fails to Adopt Consensus Best Practices for Management of Children and Adolescents with Concussion.**

368. CYSA North has also failed to adopt best practice guidelines relating to concussion management of child and adolescent individuals.

369. For example, the Zurich II Protocol states that “the evaluation and management recommendations herein can be applied to children and adolescents down to the age of 13 years ... below that age, children report concussion symptoms different from adults and would require age-appropriate symptom checklists as a component of assessment.”¹⁷⁵

370. Accordingly, the Zurich II Protocol recommends the usage and implementation of a specially designed SCAT3 sideline concussion assessment tool for individuals aged 5-12.¹⁷⁶

371. While the CYSA North Protocol provides a list of symptoms to aid an individual in determining whether a concussion occurred, CYSA North’s failure to account for and require an age-appropriate symptom checklist is in contravention of best practices.

372. The Zurich II Protocol also states:¹⁷⁷

It was agreed by the panel that no return to sport or activity should occur before the child/adolescent athlete has managed to return to school successfully. In addition, the concept of ‘cognitive rest’ was highlighted with special reference to a child’s need to limit exertion with activities of daily living that may exacerbate symptoms. School attendance and activities may also need to be modified to avoid provocation of symptoms. Children should not be returned to sport until clinically completely symptom-free, which may require a longer time frame than for adults.

373. While the CYSA North Protocol requires that a player’s parents be notified, the notification form does not: (i) indicate that a child should not return to play before the child has returned to school successfully; (ii) indicate that a more conservative return to play approach for children is necessary; or (iii) indicate that parental involvement in the treatment and evaluation of the child is necessary.

¹⁷⁵ Zurich II Protocol at 5.

¹⁷⁶ *Id.*

¹⁷⁷ *Id.* at 5-6.

374. CYSA North's failure to implement or require these consensus best practices for concussion management of children and adolescents is in contravention of best practices.

H. Each of the Defendants Has Failed to Adopt Proper Rules for Protecting Players Under 17 From Head Injuries

375. Each of the Defendants has failed to adopt rules that specially address the issues of brain injuries and/or the risk of brain injury caused by repetitive heading by players under the age of 17.

376. Players under the age of 17 have:

- Brains that are still developing – lack of myelination, less strength, nerve fibers more easily torn;
- Brains that are more sensitive to the excitotoxic shock of concussion (Second Impact Syndrome);
- Weak necks that don't distribute force to the body well plus poor head/body ratio – human bobble-head that increase risk of injury to brain and neck;
- Lighter brain than adults so less inertia more acceleration for given force;
- Weak torsos that don't keep the head from hitting the ground;
- Poor equipment;
- Poor language skills to alert coach to concussion symptoms;
- Poor access to medical resources; and
- Coaches with various levels of training.

377. Recent medical evidence indicates that the developing brain is more vulnerable to traumatic brain injury ("TBI") and has poorer outcomes after TBI.

378. After TBI, children have altered educational and social development and lower IQ and grade point average.

379. A study by Dr. Michael Lipton, *et al.* showed that with over 885 headers per year, players' brains showed abnormalities. At over 1800 headers per year, players show memory impairment.

380. These numbers are easily exceeded by the average youth player. A typical 13-year old premier player plays at least 4 times a week for 50 weeks. Assuming 5 headers per practice/game, that's at least 1,000 headers per year. Older premier players, Development Academy and high school aged players who play more frequently easily exceed 1,800 headers per year. These players are playing from the age of 8 or 9 through 17, thus they may take over 10,000 headers if not more.

381. On a piecemeal basis, certain authorities are limiting heading for games played within their authority. For example, on June 5, 2014, the Shipley School of Bryn Mawr, Pennsylvania announced that it was outlawing heading in middle school games after consulting with leading experts:

*We believe we can make significant progress by prohibiting the heading of soccer balls by Middle School students. Today's data strongly indicate that head hits for Middle Schoolers have much more impact than once believed and that too often these players have not learned to head the ball correctly, that their necks, shoulders, and backs are not well enough developed to do the task properly, and that recurring use of heading increases the incidence of short term and long term problems. And, even for those who do know how to head the ball, the prospect of head injuries is increased by force and physical contact that often occurs when the players go up in the air and compete to head a ball.*¹⁷⁸

382. If Defendants truly intended to protect youth players, the Laws of the Game would prohibit headers or limit the number of headers youth participants could take.

I. FIFA Has Failed to Adopt Proper Substitution Rules to Allow Athletes to be Evaluated During a Game

383. Although the FIFA substitution rule is not followed at the youth level, its failure to accommodate the need to evaluate injuries influences the hierarchy of rules in the lower leagues such that their rules do not call out the need to substitute and evaluate if a concussion is suspected.

¹⁷⁸ <http://sports.yahoo.com/blogs/prep-rally/pennsylvania-school-bans-heading-in-soccer-over-concussion-concerns-192911672.html>.

1 384. Under recognized FIFA rules, soccer matches in the United States are governed by
2 FIFA's rules on substitutions during a match.

3 385. FIFA rules on substitutions lead to increases in the number of concussions and raise
4 the risk of multiple concussions during a match.

5 386. FIFA's Law 3 expressly limits the number of substitutions to three players. There are
6 no rules under FIFA or USSF Laws which specifically address concussions or expanding the number
7 of substitutions. Nor are there any FIFA Laws of the Game concerning the need for substitution of
8 children and adolescents after suffering a possible concussive injury.

9 387. Accordingly, in certain domestic and international FIFA sanctioned matches played in
10 the United States, only up to three substitutions can be made during a match. Thus, even if more than
11 three players are injured during a match, and must leave the match, under Law 3 a team may not
12 replace the next injured player that must leave a match. Where three substitutions have already been
13 made for any reason, this leaves the team's coach with a dilemma to either play with less than eleven
14 players, or worse, to leave an injured player in the match in order to maintain an equal number of
15 players as the opposition.

16 388. Where players are not removed even after suffering a possible concussion, both Law 3
17 and the failure for any exceptions lead to a breach of the agreed upon consensus that Return to Play
18 should not be allowed for at least 24 hours. Neither FIFA nor USSF have made any effort to expand
19 the number of permissible substitutes for medical reasons, as opposed to tactical reasons.

20 389. Further compounding the problem, the Notes to the Laws of the Game for 2014-15
21 again allow for FIFA members to modify the number of substitutions, as well as the nature of the
22 ball, the length of the field and colors of uniforms. While FIFA allows a member association to
23 increase the number of players to be substituted to be raised from three (to a maximum of 12), this
24 modification must be agreed upon by both teams and the referee must be so advised prior to a match.
25 Thus, if one team disagrees with the number of substitutions the number cannot be increased above
26 three. And if injuries that are unforeseen occur during a match, unless the number of substitutions
27 was agreed before the match started, then injured players are at risk to continue playing.

1 390. Again, with regard to increasing the number of substitutions, there are no FIFA rules
2 in place which seek to provide guidance as to the appropriate number of increased substitutes for
3 games involving children and women footballers, which the medical consensus has clearly
4 concluded are at more risk than older male counterparts.

5 391. Law 3's limitation on the number of substitutions does not allow exceptions for
6 goalkeepers. In fact, Law 3 suggests an even heightened scrutiny for a goalkeeper to leave a game as
7 his or her exit must be called to the attention of the center referee and he or she may not leave a game
8 or be substituted for absent express consent of that Referee.

9 392. There is also no provision allowing for the substitution of an injured goalkeeper if the
10 team has gone through its allotment of substitutions. Goalkeeping is a specialized activity which
11 requires training separate and apart from the other ten field players. Accordingly, many teams carry
12 only one, two, or three trained goalkeepers. In events where the goalkeeper has become injured, and
13 the last substitution has been used, this has resulted in a dilemma for a coach to keep a concussed
14 goalkeeper remaining in a match due to a lack of an adequate substitute. The pressure on a coach to
15 leave an injured goalkeeper in a match becomes particularly acute both in a close match and as a
16 game approaches the end of a match.

17 393. Further compounding the problems caused by the number of permissible substitutions
18 under Law 3, the current laws expressly provide for the safety of a player to be controlled and
19 impacted by the Head Referee and not a medical provider.

20 394. Under FIFA Law 5, the Referee is deemed the "final authority" on those players who
21 may exit and enter a match. Under the FIFA Rules "all players are subject to the authority and
22 jurisdiction of the Referee."

23 395. Also under Law 5, the Referee is charged with determining if a player has suffered a
24 "serious injury" requiring a player to leave a match, as well as a "minor injury" which could and
25 frequently does result in the match continuing while the player remains on the field in an injured
26 condition until a natural stoppage occurs in the game such as ball going out of bounds, a foul being
27 called, or a goal being scored.

1 396. There are no provisions in the Laws of the Game which explain the difference
2 between a “Serious injury” and a “minor injury”; all grey areas are left to the “opinion” of the Head
3 Referee.

4 397. The only injury requiring a Referee to stop a match and remove a player is when a
5 player is visibly bleeding. Thus a player that has a minor abrasion on his or her leg must leave a
6 match. Conversely, a player that has suffered a concussion – with no accompanying bleeding – can
7 and often does remain in the match.

8 398. Under the Laws of the Game, a bleeding player may reenter a match if the bleeding is
9 cleaned up, has been bandaged so as to prevent contamination on another player and/or the bleeding
10 has ceased. There are no similar requirements under FIFA Rules for when a concussed player can or
11 should return to play.

12 399. The position of Head Referee is extremely demanding and becomes increasingly so as
13 the speed of the play increases and the players’ skills have become more developed. Frequently, even
14 with best efforts, a Head Referee has not seen the event that has led to a concussion. A Head Referee
15 has little to no time to examine a player that leaves a match.

16 400. Most importantly, once presented for match reentry by a coach, the Head Referee has
17 no written authority to prevent that player from reentering a match if a concussed player is not
18 bleeding or does not suffer visibly from a “Serious injury.” To the contrary, a player appearing to
19 suffer from a “minor injury” must be allowed to return to a match if the player, parent, or coach so
20 request.

21 401. As was so evident during the FIFA World Cup in Brazil, players and coaches in
22 domestic competitions in the United States are no different – regardless of the stakes a competitive
23 player will wish to return to a match instead of following the agreed upon medical consensus
24 regarding return to play.

25 402. Head Referees are also unable to prohibit a previously concussed player from
26 returning to play too soon after following post-concussive protocols. Within USSF and its domestic
27 affiliates US Club, USAYSA, and AYSO, there are no provisions which require the revocation of a
28

1 playing card until a medical provider has certified that the previously concussed player should return
2 to training, practice, or match play.

3 **J. The English Premier League Announces New Medical Rules For Head**
4 **Injuries**

5 403. On August 5, 2014, the Premier League has announced new medical rules and
6 policies regarding head injuries suffered on the pitch.

7 404. During the 2013/14 season, the Premier League Board set up a Medical Working
8 Group to look at their existing rules and policies regarding head injuries.

9 405. The Working Group was led by Premier League Director of Football, Mike Foster,
10 Chairman of the Premier League Doctors' Group and Arsenal Club Doctor, Dr. Gary O'Driscoll, FA
11 Head of Sports Medicine, Dr. Ian Beasley, and members of the PFA, LMA and Football League.

12 406. The Group was asked to review existing rules and policies and consider ways that
13 medical professionals could be further assisted in carrying out their duties. It consulted with a wide
14 range of experts, including senior medical practitioners from the Rugby Football Union and British
15 Horseracing Authority.

16 407. Their recommendations have already been addressed by Premier League clubs who
17 agreed to new rules and policies being introduced for the 2014/15 Barclays Premier League season,
18 including:

- 19 • Premier League Rules making clear that when a serious head
20 injury is suffered on the pitch (in matches or training) that the
21 ruling of the doctor/medical practitioner is final.
- 22 • The role of "Tunnel Doctors" (it is a new requirement for all
23 Premier League matches to include a Tunnel Doctor) will
24 include supporting the home and/or away team doctors in
25 helping recognise the signs of concussion.
- 26 • Making it mandatory for all Premier League medical staff to
27 carry the Concussion Recognition Tool.
- 28 • Annual baseline testing should take place on each Premier
League player.

K. Discovery of the Cause of Action, FIFA's Fraudulent Concealment, and Plaintiffs' Vulnerability

408. Prior to the 2014 World Cup, Plaintiffs and the Class were unaware that the conduct of FIFA may have caused them to be at an increased risk for developing chronic brain injury symptoms, including, but not limited to, dementia and/or Alzheimer's disease and chronic traumatic encephalopathy.

409. Until at least the 2014 World Cup, Plaintiffs and the Class did not have a reasonable basis to know or believe that the aforementioned harm was caused by the concealment, neglect, and/or misconduct of FIFA and the other defendants.

410. Leading up to the 2014 World Cup, and over the past four decades, FIFA has actively concealed any correlation between on-field concussions, its return to play policies and the chronic mental illnesses and maladies suffered by athletes, including the Plaintiffs and the Class.

411. Even today, by failing to implement appropriate policies to prevent, manage, mitigate, and remedy head injuries and concussions sustained by athletes, FIFA and the other defendants continues to ignore and actively conceal the repeated warnings and patterns of injury of which FIFA has actual knowledge.

412. Although the debilitating effects of concussions and other head injuries have already manifested for many former student-athletes, there are many others who have sustained such injuries as a direct result of FIFA's failures and inactivity described above, but whose symptoms have only partially manifested or not yet manifested at all.

413. FIFA has failed to establish a proper and adequate methodology to monitor and detect when players suffer concussive or sub-concussive injury in practice or game play. This has increased the risk of injury that will materialize in the future.

414. As a result, Plaintiffs and the Class require medical monitoring to detect the manifestation of post-injury symptoms.

V. CLASS ACTION ALLEGATIONS

A. Plaintiffs' Class Allegations

415. Plaintiffs bring this action, individually and as a class action, pursuant to the provisions of Rules 23(a) and (b)(2) and/or (b)(3) of the Federal Rules of Civil Procedure on behalf of a class defined as:

All current or former soccer players who from 2002 to the present competed for a team governed by FIFA, The United States Soccer Federation, U.S. Youth Soccer, American Youth Soccer Organization, U.S. Club Soccer, or California Youth Soccer Association.

Excluded from the Class are all persons who make a timely election to be excluded from the Class; and the judge to whom this case is assigned and any immediate family members thereof.

416. Certification of Plaintiffs' claims for class-wide treatment is appropriate because Plaintiffs can prove the elements of their claims on a class-wide basis using the same evidence as would be used to prove those elements in individual actions alleging the same claims.

417. **Numerosity – Federal Rule of Civil Procedure 23(a)(1).** The members of the Class are so numerous that individual joinder of all members of the Class is impracticable. On information and belief, there are thousands of soccer players who have been exposed to an increased risk of injury or have been damaged by defendant's wrongful conduct as alleged herein. The precise number of members of the Class and their addresses is presently unknown to Plaintiffs, but may be ascertained including from books and records of soccer organizations. Members of the Class may be notified of the pendency of this action by recognized, Court-approved notice dissemination methods, which may include U.S. mail, electronic mail, Internet postings, and/or published notice.

418. **Commonality and Predominance – Federal Rule of Civil Procedure 23(a)(2) and 23(b)(3).** This action involves common questions of law and fact, which predominate over any questions affecting individual members of the Class, including, without limitation:

- a. whether Defendants engaged in the conduct as alleged herein;
- b. whether Defendants owed a duty to Plaintiffs and the Class;
- c. whether that duty has been breached;

- d. whether Defendants failed to adopt or enforce concussion management and return to play guidelines in conformance with consensus best practices;
- e. whether Plaintiffs and members of the Class are at increased risk of injury as a result of Defendants' breach; and
- e. whether Plaintiffs and the Class are entitled to equitable relief, including, but not limited to, medical monitoring and other injunctive relief.

419. **Typicality – Federal Rule of Civil Procedure 23(a)(3).** Plaintiffs' claims are typical of the claims of the other members of the Class because, among other things, all members of the Class were comparably injured through the uniform misconduct described above.

420. **Adequacy of Representation – Federal Rule of Civil Procedure 23(a)(4).** Plaintiffs are adequate representatives of the Class because their interests do not conflict with the interests of the members of the Class they seek to represent; they have retained counsel competent and experienced in complex commercial and class action litigation; and Plaintiffs intend to prosecute this action vigorously. The interests of the Class will be fairly and adequately protected by Plaintiffs and their counsel.

421. **Declaratory and Injunctive Relief – Federal Rule of Civil Procedure 23(b)(2).** Each Defendant has acted or refused to act on grounds generally applicable to Plaintiffs and the members of the Class, thereby making appropriate final injunctive relief and declaratory relief, as described below.

422. **Superiority – Federal Rule of Civil Procedure 23(b)(3).** A class action is superior to any other available means for the fair and efficient adjudication of this controversy, and no unusual difficulties are likely to be encountered in the management of this class action. The costs of medical monitoring to be incurred by Plaintiffs and members of the Class are relatively small compared to the burden and expense that would be required to individually litigate their claims against Defendants, so it would be impracticable for members of the Class to individually seek redress for Defendants' wrongful conduct. Even if members of the Class could afford individual litigation, the court system could not. Individualized litigation creates a potential for inconsistent or contradictory judgments, and increases the delay and expense to all parties and the court system. By

1 contrast, the class action device presents far fewer management difficulties, and provides the benefits
2 of single adjudication, economy of scale, and comprehensive supervision by a single court.

3 **VI. CLAIMS ALLEGED**

4 **COUNT I** 5 **NEGLIGENCE** 6 **(On Behalf of the Class)**

7 423. Plaintiffs adopt and incorporate by reference all prior paragraphs of this Complaint as
8 if fully set forth herein.

9 424. At all relevant times, each Defendant had a duty toward Plaintiffs and the Class to
10 supervise, regulate, monitor, and provide reasonable and appropriate rules to minimize the risk of
11 injury to the players.

12 425. FIFA and each Defendant acted carelessly and negligently in their positions as the
13 regulatory bodies for soccer and soccer players, including Plaintiffs and the Class. In addition, FIFA
14 and U.S. Soccer knew or should have known that their actions or inaction in light of the rate and
15 extent of concussions reported and made known to FIFA and U.S. Soccer would cause harm to
16 players in both the short- and long-term.

17 426. FIFA and U.S. Soccer knew that through the power of the Laws of the Game they had
18 the power to direct and influence how the rest of the defendants treat concussion management issues.

19 427. The non-FIFA and U.S. Soccer Defendants had an independent duty to enact and
20 enforce Laws of the Game that properly protect players.

21 428. Each Defendant was careless and negligent by breaching the duty of due care it
22 assumed for the benefit of the Plaintiffs and the Class, both generally and in the following particular
23 respects as set forth above and summarized below:

- 24 a. Failing to educate players and their parents concerning
25 symptoms that may indicate a concussion has occurred;
- 26 b. Failing to warn of the risk of unreasonable harm resulting from
27 repeated concussions, the accumulation of subconcussive hits,
28 and heading;
- c. Failing to disclose the risks of long-term complications from
repeated concussions and return to play;

- d. Failing to disclose the role of repeated concussions or accumulation of subconcussive hits in causing chronic life-long cognitive decline;
- e. Failing to promulgate rules and regulations to adequately address the dangers of repeated concussions and accumulation of subconcussive hits, and a return to play policy to minimize long-term chronic cognitive problems;
- f. Concealing and misrepresenting pertinent facts that players and parents needed to be aware of to make determinations of the safety of return to play;
- g. Failing to adopt rules and reasonably enforce those rules to minimize the risk of players suffering debilitating concussions; and
- i. Other acts of negligence or carelessness that may materialize during the pendency of this action.

429. It was reasonable and foreseeable to FIFA and U.S. Soccer that their failures would flow downstream to the Rules and Laws of the Game enacted by other organizations, including the other Defendants in this action.

430. The Plaintiffs individually and the Class members play soccer and are at risk due to Defendants' breaches.

431. As a result of the foregoing, the Plaintiffs and the Class have an improper risk of injury caused by the misconduct of the Defendants.

432. The Plaintiffs and the Class are entitled to injunctive relief requiring each Defendant, among other things, to adopt corrective measures regarding: the implementation of system-wide "return to play" guidelines for athletes who have sustained concussions; the implementation of system-wide guidelines for the screening and detection of head injuries; failing to implement substitution Rules for medical evaluation purposes and failing to regulate heading by players under 17. Plaintiffs are also entitled to the remedy of medical monitoring.

433. Moreover, Plaintiffs have no adequate remedy at law in that monetary damages cannot compensate them for the risk of long-term physical and economic losses due to concussions

1 and sub-concussive injuries. Instead, Plaintiffs are in need of medical monitoring as a remedy for
 2 Defendants' negligence where permitted under state law.

3 **COUNT II**
 4 **BREACH OF VOLUNTARY UNDERTAKING**
 (On Behalf of the Class)

5 434. Plaintiffs adopt and incorporate by reference all prior paragraphs of this Complaint as
 6 if fully set forth herein.

7 435. At all relevant times, each Defendant voluntarily assumed a duty toward Plaintiffs and
 8 the Class to supervise, regulate, monitor, and provide reasonable and appropriate rules to minimize
 9 the risk of injury to the players.

10 436. FIFA and each Defendant acted carelessly and negligently in fulfilling their assumed
 11 duties as the regulatory bodies for soccer and soccer players, including Plaintiffs and the Class. In
 12 addition, FIFA and U.S. Soccer knew or should have known that their actions or inaction in light of
 13 the rate and extent of concussions reported and made known to FIFA and U.S. Soccer would cause
 14 harm to players in both the short- and long-term.

15 437. FIFA and U.S. Soccer knew that through the power of the Laws of the Game they had
 16 the power to direct and influence how the rest of the defendants treat concussion management issues
 17 and by publication of the Laws of the Game assumed a duty to protect Plaintiffs and the Class.

18 438. The non-FIFA and U.S. Soccer Defendants had an independent assumed and
 19 voluntary duty to enact and enforce Laws of the Game that properly protect players.

20 439. Each Defendant was careless and negligent by breaching their assumed and voluntary
 21 duty of due care for the benefit of the Plaintiffs and the Class, both generally and in the following
 22 particular respects as set forth above and summarized below:

- 23 a. Failing to educate players and their parents concerning
- 24 symptoms that may indicate a concussion has occurred;
- 25 b. Failing to warn of the risk of unreasonable harm resulting from
- 26 repeated concussions, the accumulation of subconcussive hits,
- 27 and heading;
- 28 c. Failing to disclose the risks of long-term complications from
- repeated concussions and return to play;

- d. Failing to disclose the role of repeated concussions or accumulation of subconcussive hits in causing chronic life-long cognitive decline;
- e. Failing to promulgate rules and regulations to adequately address the dangers of repeated concussions and accumulation of subconcussive hits, and a return to play policy to minimize long-term chronic cognitive problems;
- f. Concealing and misrepresenting pertinent facts that players and parents needed to be aware of to make determinations of the safety of return to play;
- g. Failing to adopt rules and reasonably enforce those rules to minimize the risk of players suffering debilitating concussions; and
- i. Other acts of negligence or carelessness that may materialize during the pendency of this action.

440. It was reasonable and foreseeable to FIFA and U.S. Soccer that their failures would flow downstream to the Rules and Laws of the Game enacted by other organizations including the other Defendants in this action.

441. The Plaintiffs individually and the Class members play soccer and are at risk due to Defendants' breaches.

442. As a result of the foregoing, the Plaintiffs and the Class have an improper risk of injury caused by the misconduct of the Defendants.

443. The Plaintiffs and the Class are entitled to injunctive relief requiring each Defendant, among other things, to adopt corrective measures regarding: the implementation of system-wide "return to play" guidelines for athletes who have sustained concussions; the implementation of system-wide guidelines for the screening and detection of head injuries; failing to implement substitution Rules for medical evaluation purposes and failing to regulate heading by players under 17. Plaintiffs are also entitled to the remedy of medical monitoring.

444. Moreover, Plaintiffs have no adequate remedy at law in that monetary damages cannot compensate them for the risk of long-term physical and economic losses due to concussions

1 and sub-concussive injuries. Instead, Plaintiffs are in need of medical monitoring as a remedy for
 2 Defendants' negligence where permitted under state law.

3 **COUNT III**
 4 **MEDICAL MONITORING**
 (On Behalf of the Class)

5 445. Plaintiffs adopt and incorporate by reference all prior paragraphs of this Complaint as
 6 if fully set forth herein. Plaintiffs bring this Count III under the laws of the states in which they
 7 reside and assert claims on behalf of the Medical Monitoring Class under the laws of the states in
 8 which class members reside.

9 446. The Medical Monitoring Class has been exposed to a greater risk of concussions and
 10 sub-concussions, which have created an increased risk of long-term injury and the illnesses as
 11 described above.

12 447. The members of the Medical Monitoring Class have not yet fully manifested the long-
 13 term physical and mental effects of FIFA's and each Defendant's misconduct, and require
 14 specialized testing that is not generally given or available to the public at large for the early detection
 15 of the long-term effects of concussions and sub-concussions.

16 448. Medical monitoring is reasonably necessary according to contemporary scientific
 17 principles within the medical community that specialize in close head injuries and their connection to
 18 memory loss, early onset dementia, CTE and Alzheimer-like syndromes.

19 449. By monitoring and testing former (and current) soccer athletes who are believed to
 20 have suffered a concussion or sub-concussion while playing or practicing, the risk of each such
 21 player suffering long-term injuries, disease, and losses as described above will be significantly
 22 reduced.

23 450. Accordingly, FIFA and each Defendant should be required to establish a medical
 24 monitoring program that includes, among other things:

- 25 a. Establishing a trust fund, in an amount to be determined, to pay
 26 for the medical monitoring of all past, current, and future FIFA
 athletes, as frequently and appropriately as necessary;
- 27 b. Notifying all Medical Monitoring Class members in writing
 28 that they may require frequent medical monitoring; and

- 1 c. Providing information to treating team physicians to aid them
2 in detecting concussion or sub-concussions and to assist them
3 in determining when the student-athlete is subjected to an
4 increased risk of harm.

4 451. Plaintiffs and the Medical Monitoring Class have no adequate remedy at law in that
5 monetary damages cannot compensate them for the risk of long-term physical and economic losses
6 due to concussions and sub-concussive injuries. Without a Court-approved medical monitoring
7 program as described herein, or established by the Court, Plaintiffs and the Medical Monitoring
8 Subclass members will continue to face an unreasonable risk of injury and disability.

9 **REQUEST FOR RELIEF**

10 WHEREFORE, Plaintiffs, individually and on behalf of the Class, request judgment as
11 follows:

- 12 A. Certification of the proposed Class pursuant to Federal Rules of Civil Procedure Rule
13 23(a), (b)(2) and (b)(3);
- 14 B. Designation of Plaintiffs as representatives of the proposed Class and designation of
15 Plaintiffs' counsel as Class counsel;
- 16 C. Injunctive relief;
- 17 E. The establishment of a medical monitoring program;
- 18 F. An award to the Plaintiffs and the Class of costs, and attorneys' fees; and
- 19 G. An award to the Plaintiffs and Class for such other and further relief as the Court
20 deems just and proper.

21 **JURY DEMAND**

22 Pursuant to Federal Rule of Civil Procedure 38(b), Plaintiffs demand a trial by jury of all
23 claims in this Complaint so triable.

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1 Date: August 27, 2014

Respectfully submitted,

3 By /s/ Jon T. King

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